

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9812(g)(3)	In this situation, (no PD exists), Labor Code section 4062.1 does not indicate a 10 day time limit in which a panel may be requested. Most claims administrators would want some sort of time limit but commenter does not think one exists in the statute or the regulations. Suggests one year from the last payment of benefit.	Anthony Velasquez November 30, 2006 Written Comment	This comment is unrelated to benefit notice regulations and is, therefore, beyond the scope of the regulatory proceeding.	None.
Section 9767.16(c)	This subdivision provides that a notice "shall" inform covered employees that they "may be entitled to continuity of care, pursuant to section 9767.10 of these regulations...." Commenter agrees that providing such information is important, but it must be recognized that many injured workers will not have ready access to "section 9767.10 of these regulations." Accordingly, commenter recommends that the proposed language be amended to specify that the notice include, at the very least, a brief and understandable ( <i>i.e.</i> , written in plain language) description of the conditions under which the worker will be eligible for continuity of care.	Linda F. Atcherley, President – California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9810(d)	In order to clarify the intent of this paragraph, commenter recommends that it be amended to read:  <u>(d) Benefit notices, except those mandatory notices set forth in statute or specific notice forms that have been adopted by regulation, may be produced in any format developed by the claim administrator. Each such benefit notice shall contain all relevant notice elements required by either statute or regulation. The administrative director shall make sample notices that comply with these</u>	Linda F. Atcherley, President – California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<u>requirements available on the DWC website.</u>			
Section 9810(e)	<p>The proposed new language dealing with medical reports "which are not required to be provided along with a notice" is confusing. The commenter interprets this clause is saying that if a medical report has already been provided to the employee because the report was "required to be provided along with the notice," the claims administrator is not required to send another copy of the report to the employee. If this interpretation is correct, commenter believes this clause is superfluous because the preceding clause already excuses the claims administrator from providing any notice which has already been provided to the employee. If our interpretation is not correct, we strongly recommend that this clause be rewritten to clarify its meaning.</p> <p>In order to clarify the intent of this subdivision, commenter recommends that it be amended to read:</p> <p><del>(d)</del> (e) The claims administrator shall <del>make available</del> <u>provide copies</u> to the employee, upon request, <del>copies of all</del> <u>copies of all</u> medical reports <u>relevant to any benefit notice issued, but which have not already been provided,</u> other than psychiatric reports which the physician has recommended not be provided to the employee.</p>	Linda F. Atcherley, President – California Applicants’ Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	The Administrative Director accepts this comment, but does not accept the commenter’s suggested language.	Amended language has been distributed for public comment.
Section 9811(e)	The mandatory statement of remedies for employees subject to an Alternative Dispute Resolution program under Labor Code §§ 3201.5 or 3201.7 includes the following	Linda F. Atcherley, President – California Applicants’ Attorneys Association via	<p>The Administrative Director accepts this comment in part.</p> <p>The proposed language states that the</p>	Amended language has been distributed for public comment.

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	<p>proposed wording:</p> <p><u>In accordance with the (insert union name) agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. Your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.</u></p> <p>This statement is incorrect. It is correct that some of the ADR programs formed under the original authorizing statute, Labor Code §3201.5, did not allow the employee to bring his or her attorney into the room during the ombudsman and mediation stages, although the employee could leave the room and consult with an attorney at any time. However, there is no prohibition in §3201.5 against the active participation by an attorney in any stage of the ADR process, and, in fact, many of the programs formed under this section allow full participation by attorneys at all stages. Furthermore, newly adopted Labor Code §3201.7(b)(1) specifically provides that: <i>"nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages during the alternative dispute resolution process."</i></p>	<p>Mark Gerlach December 11, 2006 Written Comment</p>	<p>proposed language may be substituted where appropriate. However, in order to improve the clarity of the subdivision, it will be amended to clarify that the language to which the comment objects may only be relevant to an ADR program under Labor Code section 3201.5.</p>	

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	<p>Thus, it is incorrect to tell workers in <u>all</u> carve-out programs that participation by their attorney is limited. Accordingly, commenter recommends that the above section be deleted, replaced by the following provision which is based upon the statutory language mandated for inclusion in a claim form under Labor Code §5401(b)(9)(C) :</p> <p><u>You also have the right to consult with an attorney of your choice. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. Most alternative dispute labor agreements allow active participation by an attorney in all stages of the ADR workers' compensation process. For names of workers' compensation attorneys, call the State Bar of California at (insert phone number of the State Bar of California's legal specialization program, or its equivalent).</u></p>			
Section 9812(a)(2)	<p>One of the amendments proposed to this paragraph specifies that any additional notice sent by a claims administrator notifying the employee of a delay in the payment of temporary disability indemnity must be sent no later than the original determination date. Similar amendments are proposed in §9812(e)(3). Commenter supports these changes. Delaying this notice for an additional 5 days, as allowed under the current regulations, simply adds to the workload of adjusters, I &amp; A officers, and attorneys when injured workers contact them to find out the status of their benefits. This adds unnecessary</p>	<p>Linda F. Atcherley, President – California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>While the Administrative Director appreciates this comment, the comment does not constitute an objection or recommendation that requires explanation or accommodation pursuant to Government Code §11346.9(a)(3).</p>	<p>None.</p>

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	<p>costs to the system, which like all system costs, are passed on to employers. Requiring that any additional notice be provided no later than the original determination date is simply common sense, and will eliminate these unnecessary added costs.</p> <p>Paragraph (2) also outlines specific information that must be included in notices for unrepresented workers to describe the medical-legal evaluation process set forth in Labor Code §4062.1. Under §4062.1(b), an unrepresented worker has the right to designate the specialty of the physician to be assigned to a panel, but the worker can lose this right if he or she does not submit the QME panel selection form within 10 days. Under §4062.1(c), the unrepresented worker has the right to select the evaluating physician from the panel, but again can lose that right if he or she does not inform the employer of the selection within 10 days. These are substantive rights, and commenter believes that the proposed language that states "<i>The notice shall advise the injured worker of the 10 day time limit...</i>" does not protect these important rights.</p> <p>Instead, commenter strongly recommends that notices to unrepresented workers be required to include mandatory language informing them of their rights and responsibilities under §4062.1. This language should be enclosed in a "box" located at or near the top of the notice, and the regulation should further require that this language be printed in bold face type, minimum size 16 point. Although insurers</p>		<p>The Administrative Director accepts this comment in principle, but believes that the approach suggested by Voters Injured at Work (placing a warning to the employee on the envelope) would better achieve the desired result.</p>	<p>Amended language has been distributed for public comment.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>will undoubtedly assert that this would be an unnecessary expense, this special attention is imperative. The typical injured worker has little or no knowledge of the workers' compensation system, and benefit notices must be designed so that these workers are fully aware of what the potential benefits are and what is required of them to receive those benefits. Burying a potentially confusing description of these critical 10-day time limits in the small print of what could be a multi-page notice will inevitably have the effect of denying many workers these substantive rights.</p> <p>For these unrepresented workers, commenter recommends that the following language be required in a "box" at the top of each notice in which the worker is informed of his or her remedies in case of a dispute:</p> <p style="text-align: center;"><b>WARNING</b></p> <p style="text-align: center;"><b>YOU MAY LOSE IMPORTANT RIGHTS IF YOU DO NOT TAKE CERTAIN ACTIONS WITHIN 10 DAYS. READ THIS LETTER AND THE ENCLOSED AME/QME FACT SHEET CAREFULLY.</b></p>			
Section 9812(a)(3)	<p>Commenter states that thw previous comments on Section 9812(a)(2) should apply to notices of denial of any temporary disability indemnity payments. For unrepresented workers, it is recommended that the above mandatory warning box be required on every notice of denial of TTD benefits.</p>	<p>Linda F. Atcherley, President – California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>Please see the response to comment immediately above.</p>	<p>None.</p>

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	<p>Paragraph (3) also includes the first of several identical changes that require a claim administrator to provide a copy of a DWC informative pamphlet to the injured worker, but eliminates this requirement if "a copy has already been provided." Commenter recommends that this qualification be eliminated and that copies of the relevant pamphlets be required to be provided with all notices. This is appropriate because it is not unusual for workers to have periods of temporary disability that can be separated by months or even years, and it often takes years to resolve claims that involve permanent disability.</p> <p>Although providing the required information pamphlet with each notice will involve some minor additional expense, this will be both cheaper and more effective in the long run. Any savings to claim administrators from not sending pamphlets with some notices will be offset by the additional cost of trying to determine which notices should include the pamphlet, the cost of penalties when they get it wrong, and the cost of responding to workers who are confused about their benefits when they receive a notice without an explanatory pamphlet. Commenter believes this will also reduce the burden on I&amp;A officers, as well as attorneys, who otherwise will be contacted by injured workers confused by the benefit notice. Considering these potential costs when informative pamphlets are <u>not</u> provided, it would not be a burden to require that claims administrators provide the</p>		<p>The Administrative Director accepts this comment.</p>	<p>Amended language has been distributed for public comment.</p>

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	<p>appropriate pamphlets with every notice.</p> <p>Commenter recommends that the clause "Unless a copy has already been provided" be deleted from this paragraph, as well as the other instances it is used in these proposed regulations.</p>			
Section 9812(d)	<p>This subdivision sets out a requirement that the claims administrator "make an accounting of all compensation paid to or on behalf of the employee" along with the last payment of any indemnity benefit. Although this wording is in the current regulations, it is somewhat vague and unclear. Commenter believes the intent of this provision is that the claims administrator <i>provide to the employee</i> an accounting of all compensation paid, and recommends that the language be amended as follows:</p> <p>(d) Notice that Benefits are Ending (TD, SC, PD, VRTD/VRMA). With the last payment of temporary disability indemnity, permanent disability indemnity, salary continuation, or vocational rehabilitation temporary disability indemnity or maintenance allowance, the claims administrator shall advise the employee of the ending of indemnity payments and the reason, and shall <del>make</del> <u>provide to the employee</u> an accounting of all compensation paid to or on behalf of the employee in the species of benefit to which the notice refers, including the dates and amounts paid and any related penalties. If the decision to end payment of indemnity was made after the last payment, the</p>	<p>Linda F. Atcherley, President – California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>The Administrative Director does not accept this comment. The current language clearly requires the notice to contain the accounting.</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>claims administrator shall send the notice and accounting within 14 days of the last payment. <del>The notice shall include the employee's remedies.</del></p> <p>Subdivision (d) also requires that notices sent out with the last payment of any indemnity benefit must include information about the worker's rights and responsibilities under §4062.1. Commenter again recommends that when this notice is provided to unrepresented workers that it include the mandatory warning box described above under §9812(a)(2).</p>		<p>The Administrative Director accepts this comment in principle, but believes that the approach suggested by Voters Injured at Work (placing a warning to the employee on the envelope) would better achieve the desired result.</p>	<p>Amended language has been distributed for public comment.</p>
Section 9812(f) and (g)	<p>These subdivisions govern permanent disability notices for injuries occurring during the time period from 1991 through the current date. According to the proposed language, each notice provided to a represented worker must advise the worker that any medical-legal evaluator must be selected in accordance with Labor Code §4062.2. Although commenter supports this attempt to make certain that injured workers are given information about their remedies, the proposed language is inconsistent with statute and case law and must be amended.</p> <p>Labor Code §4062.2, subdivision (a) states:</p> <p><i>(a) Whenever a comprehensive medical evaluation is required to resolve any dispute arising out of an injury or a claimed injury occurring on or after January 1, 2005, and the employee is represented by an attorney, the evaluation shall be obtained only as</i></p>	<p>Linda F. Atcherley, President – California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>The Administrative Director accepts this comment.</p>	<p>Amended language has been distributed for public comment.</p>

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	<p><i>provided in this section.</i> [Emphasis added.]</p> <p>This provision, and its possible application to claims with dates of injury before 1/1/05, was interpreted by the Workers' Compensation Appeals Board in its en banc decision of <i>Marilyn Simi v. Sav-Max Foods, Inc.</i> (2005) 70 CCC 217. The Board held in <i>Simi</i>, "that for injuries occurring prior to January 1, 2005, section 4062, as it existed before its amendment by SB 899, continues to provide the procedure by which Agreed Medical Evaluation (AME) and QME medical-legal reports are obtained in cases involving represented employees."</p> <p>Consequently, the requirement that claim adjusters advise represented workers with dates of injury prior to January 2005 of the §4062.2 medical-legal evaluation procedure violates both the plain language of §4062.2(a) and the <i>Simi</i> en banc decision and should be deleted.</p> <p>For represented workers with dates of injury prior to January, 2005, the language of the <u>current</u> subdivisions (f) and (g) (as they apply to represented workers) could be re-adopted without any amendment, with the heading for subdivision (g) amended to read: "Permanent Disability Notices for Injuries Occurring on or after January 1, 1994 <u>and before January 1, 2005.</u>" In addition, a new subdivision (h) could be adopted with a heading of "Permanent Disability Notices for Injuries</p>			

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	<p>Occurring on or after January 1, 2005" to incorporate the wording of subdivision (g) as currently proposed.</p> <p>With respect to unrepresented workers, the <i>Simi</i> decision did not address the effective date of §4062.1, nor are we aware of any case law on this issue. Consequently, commenter will only reiterate the recommendation that any time these regulations require that an unrepresented worker be advised of his or her rights and responsibilities under §4062.1, that the notice be required to include the mandatory warning box described above, printed in large, bold-face type and placed at or near the top of the notice.</p>		<p>The Administrative Director accepts this comment in principle, but believes that the approach suggested by Voters Injured at Work (placing a warning to the employee on the envelope) would better achieve the desired result.</p>	<p>Amended language has been distributed for public comment.</p>
Section 9812(g)(2)	<p>This paragraph regulates permanent disability notices provided to injured workers with the last payment of temporary disability. Current language in this paragraph requires the claims administrator to "advise the employee of the claims administrator's determination of the amount of permanent disability indemnity payable...." Commenter supports the amendments to this paragraph to provide workers with information about their remedies if they object. However, commenter believes that the current wording should be revised to make it clear that the "determination of the amount of permanent disability payable" is only the best estimate of the claim administrator and may or may not be the final amount. The problem is that even when injured workers are given a generic notice that they have certain remedies, in far too many cases workers are still unaware that they can dispute what appears to be a final</p>	<p>Linda F. Atcherley, President – California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>The Administrative Director accepts this comment in part.</p>	<p>Amended language has been distributed for public comment.</p>

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	<p>determination of permanent disability. In order to clarify this for workers, it is recommend that this paragraph be amended to read as follows:</p> <p>(2) Condition Becomes Permanent and Stationary, Causes Permanent Disability – Notice of QME/<u>AME</u> Procedures. Together with the last payment of temporary disability or within 14 days of <del>determining the amount of permanent disability payable, the knowledge that the injury is permanent and stationary or has caused permanent disability, the claims administrator shall provide notice of the procedures available to obtain a QME or AME evaluation.</del> The claims administrator shall advise the employee of the claims administrator's determination of the amount of permanent disability indemnity payable, the basis for the determination, <u>and that this determination is only an estimate and that this may or may not be the final amount. In addition, the claims administrator shall advise the employee whether there is need for continuing medical care. A copy of the medical report on which the determination of permanent disability was based, a copy of the most recent version of the DWC informative pamphlets, QME/AME Fact Sheet and/or Temporary Disability Fact Sheet, shall be provided with the notice.</u></p>			
Section 9812(i)(j)	Subdivision (i) regulates notices denying liability for all benefits. New proposed	Linda F. Atcherley, President – California	The Administrative Director does not accept this comment. At the delay	None.

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	<p>language requires the claims administrator to advise injured workers of their entitlement to medical treatment under Labor Code §5402(c). This notice is also required to be provided under subdivision (j) which regulates notices of delay in determining liability. However, commenter believes that both of these provisions should be revised.</p> <p>Specifically, the wording of subdivision (j)(2) provides a much more understandable explanation of the medical treatment benefit available under §5402(c). Subdivision (j)(2) also provides that every worker receiving a delay notice must be informed of this benefit; similarly, every worker who receives a denial notice must also be advised of this benefit. However, subdivision (j)(2) does not include the wording included in subdivision (i) which requires the claim administrator to advise the worker to send all medical bills to the administrator for consideration of payment. Accordingly, it is recommend that the following language be used for both subdivisions:</p> <p><u>For claims reported on or after April 19, 2004, regardless of date of injury, the notice shall include an explanation that Labor Code section 5402(c) provides that within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treatment guidelines, for the alleged injury and shall continue to provide treatment until the date that</u></p>	<p>Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>stage, requesting bills would be premature. It would be more efficient to wait until the claim is accepted or denied.</p>	

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	<u>liability is rejected. The notice shall advise the injured worker that the employer's liability for medical treatment under this Labor Code section is limited to ten thousand dollars (\$10,000), and shall advise the injured worker to send all bills for such treatment to the claims administrator for consideration of payment, unless he or she has already done so.</u>			
General Comment	<p>The proposed changes to the benefit notice program will create a monumental task for SCE in terms of the physical man hours it will take to review, draft, and reprogram all of the benefit letters in our claims management system. The creation of new letters will require additional staff to review the letters for accuracy and corrections in addition to a team of people (Claims, Operations and IT) that will conduct user acceptance testing to make certain that the new letters are functioning properly. Commenter's organization has a combination of manual and automated systems in place to operate the benefit notice program and will have to modify such to comply with the proposed regulations.</p> <p>Commenter's primary goal as an employer and a claims administrator is to assist our injured employees with their benefits and the time taken to implement the proposed regulations would be better spent helping our injured employees.</p> <p>It is for these reasons that commenter strongly encourages the Acting Administrative Director not to impose any changes to the</p>	<p>Joe Carresi Project Manager Workers' Compensation Southern California Edison (SCE) December 11, 2006 Written Comment</p>	<p>The Administrative Director does not accept this comment. We expect any costs to be offset by a reduction in disputes and litigation.</p>	<p>None.</p>

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	benefit notice program that are not required by new statute.			
Fact Sheets	<p>The requirements to serve “Fact Sheets” along with the specific benefit notices should either be discretionary or eliminated in its entirety.</p> <p>Basis for opinion:</p> <ul style="list-style-type: none"> <li>The proposed regulations are still requiring the use of specific fact sheets in addition to the benefit notices. In as much as the statute does require claims administrators to provide <i>certain</i> specific information to injured workers, it is noted that the acting administrative director has not cited any statutory authority that authorizes the use of fact sheets for that purpose.</li> <li>The proposed regulations do not include a provision to ensure that the information contained in the fact sheets will be maintained/updated on a regular basis.</li> <li>With regulatory changes occurring in 2005 and 2006 along with ongoing changes brought on by case law, the fact sheets will become obsolete, outdated, and misleading as soon as they are put into circulation.</li> </ul>	<p>Joe Carresi Project Manager Workers’ Compensation Southern California Edison (SCE) December 11, 2006 Written Comment</p>	<p>The Administrative Director does not accept this comment. The Administrative Director has the authority and discretion to prescribe reasonable benefit notice requirements. The Division believes that the benefits of the proposed requirement to provide injured workers with informative pamphlets concerning temporary disability benefits, permanent disability benefits or the Agreed Medical Evaluator/Qualified Medical Evaluator (“AME/QME”) medical evaluation process outweigh the costs.</p> <p>The Division believes that providing injured workers with a minimal level of basic information concerning the three most important benefits will improve the quality of communication between injured workers and claims administrators, and reduce friction and miscommunications - which may result in a decrease in disputes requiring resolution through litigation.</p> <p>The Administrative Director intends to update the facts sheets as often as needed to ensure their accuracy.</p>	None.
Section 9810(a) Effective Date	The regulations, as proposed, will have a major impact on our benefit notice program	Joe Carresi Project Manager	The Administrative Director accepts this comment and will extend the	Amended language has been distributed for

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	and as previously noted this will require a significant amount of reprogramming, testing, etc. It is noted that the regulations include a "60" day grace period from the effective date to be in compliance with the regulations. It is felt that 60 days is not a sufficient period of time to complete programming and testing and therefore this period should be extended to a minimum of 90-120 days.	Workers' Compensation Southern California Edison (SCE) December 11, 2006 Written Comment	effective date until 120 days after filing with the Secretary of State.	public comment.
Section 9812	<p>The proposed regulations include the following language in sections <b><u>(a)(2), (e)(3), (f)(1), (h)(3), and (j).</u></b></p> <p><del>The claims administrator shall send an additional notice or notices within 5 days after the determination date it specified, to advise of any further delay. If the claims administrator cannot make a determination by the date specified in a notice to the injured worker, the claims administrator shall send a subsequent delay notice to the injured worker, not later than the determination date specified in the previous delay notice, notifying the injured worker of the revised date by which the claims administrator now expects the determination to be made.</del></p> <p>It is suggested that wherever this proposed change appears, the new language should be deleted and the original language be retained.</p> <p><i>The claims administrator shall send an additional notice or notices within 5 days after the determination date it specified, to advise of any further delay.</i></p> <p>The current regulations are clear and concise</p>	Joe Carresi Project Manager Workers' Compensation Southern California Edison (SCE) December 11, 2006 Written Comment	The Administrative Director does not accept this comment. The existing regulations allow for a 5 day gap between when an injured worker was told to expect a determination, and when he or she is told that that determination will be delayed. This often results in phone calls to an adjuster, I & A officer, or attorneys or the commencement of proceedings before the WCAB.	None.



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	<p>section sets up new 10-day time limits for an unrepresented worker both to request a QME panel and to select a physician from the panel.</p> <p>The proposed regulations do require that notices inform unrepresented workers of these 10-day time limits. However, if the notice doesn't highlight these new time limits, most injured workers will never see it. Quite frankly, a lot of what injured workers receive from insurance companies is almost unreadable, and unless a notice highlights something this important, most workers are not going to see it.</p> <p>Under labor code section 124, the division has a statutory responsibility to "protect the interests of injured workers who are entitled to the timely provision of compensation." to meet this goal, commenter recommends that any notice informing unrepresented workers of their rights under section 4061.1 must include a mandatory warning spelling out, in plain English, just what the worker has to do. And this warning can't be buried in the middle of a complicated notice where most workers will never see it. It must be right on top; so that workers will see it and know that they have to do something right away.</p> <p>The right to select the specialty of the QME, and to select the QME off the panel, is critically important to an unrepresented worker – that's why the labor code gives these rights to the worker. But too many workers will lose those rights unless they understand</p>			

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	the new 10-day time limits in the law. Commenter strongly urges that the division revise these proposed regulations to include a mandatory warning notice to unrepresented workers, to be placed prominently at the top of the notice, so that they will know that they have to take immediate action.			
General Comment	Commenter approves of the proposed regulations.	Christine D. Coakley The Boeing Company December 12, 2006 Written Comments	While the Administrative Director appreciates this comment, the comment does not constitute an objection or recommendation that requires explanation or accommodation pursuant to Government Code § 11346.9(a)(3).	None.
General Comment	<p>As stressed in previous commentary, it is important for the Division to be aware of the extent to which the regulated community has maintained the benefit notice program and complied with the statutory notice requirements. The Division must also be cognizant of the mechanics, operational implications, and cost of reprogramming and the necessary personnel to maintain the automated notice system. Claims organizations have not waited for the regulations to augment the benefit notice program, but have, for the most part, already revised their notices, letters, and informational materials to comply with the latest statutory changes.</p> <p>The benefit notice program that is currently in place is based on statutory and regulatory requirements to keep injured workers fully informed of their rights and the status of their benefit payments. Maintaining complete and accurate information on the workers'</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	This comment constitutes a general objection to the adoption of the regulations based on conclusory allegations of failure to meet APA standards and questioning the need for the regulations. The comment does not make recommendations or objections addressing any specific sections of the regulations. Generalized objections such as this one do not require specific responses pursuant to Government Code §11346.9(a)(3).	None.

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	<p>compensation system is a monumental endeavor, which has already been undertaken by insurers and employers. In response, claims administrators, insurers, and employers have developed both manual and automated systems to operate the benefit notice program and maintain open and expeditious communication with injured workers. The statutory and regulatory mandates of the benefit notice program cannot be accomplished with manual systems alone; therefore, the claims administrators must rely, to a great extent, on automation. The benefit notice program is enormously complicated, difficult to administer, and very expensive. Changes to that process often have broad, unforeseen effects.</p> <p>Reprogramming systems to implement all the proposed changes to the benefit notice program would cost hundreds of thousands of dollars for even medium-sized claims operations. Some of the proposed attachment notices (Fact Sheets) would require new personnel just to stuff envelopes because they cannot be programmed into an automated system, or the supplemental notices would have to be mailed separately, incurring a 100% increase of the current cost of postage and handling.</p> <p>It is for these reasons the commenter urges Administrative Director (AD) not to impose any changes to the benefit notice program that are not absolutely required by the new statutes.</p>		<p>The Administrative Director does not accept this comment concerning the requirements to provide injured workers facts sheets. We expect any costs to be offset by a reduction in disputes and litigation.</p>	None.
Fact Sheets	<b>Recommendation</b>	Robert E. Young	The Administrative Director does not	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>All of the requirements to serve “Fact Sheets” in addition to the specific benefit notices should be deleted or made discretionary for the claims administrator.</p> <p><b>Discussion</b></p> <p>Several proposed regulations still require that claims administrators send injured employees boilerplate Fact Sheets in addition to the notices required by statute.</p> <p><u>Information and Assistance:</u> Labor Code Section 139.6 establishes within the Division of Workers' Compensation a continuing program to provide information and assistance to injured employees and employers. The requirements of section 139.6 are very explicit. The statute requires that the Division not only prepare and publish the informational material, but distribute it as well. However, rather than mandating that injured workers receive these materials in all cases or in conjunction with other benefit notices, the statute only requires the Division to provide this information if the injured worker or other interested party requests it – recognizing that inundating every claimant with a blizzard of unsolicited general information would confuse injured workers, fail to communicate the needed information, and add unnecessary expense for the state. Specifically, the section requires the Division to do the following:</p> <p><u>Section 139.6</u> (a) The administrative director shall establish and effect within the Division of Workers' Compensation a continuing</p>	<p>Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	<p>accept this comment. The Administrative Director has the authority, pursuant to Labor Code sections 138.3 and 138.4, and the discretion to prescribe reasonable benefit notice requirements. The Division believes that the benefits of the proposed requirement to provide injured workers with informative pamphlets concerning temporary disability benefits, permanent disability benefits or the Agreed Medical Evaluator/Qualified Medical Evaluator (“AME/QME”) medical evaluation process outweigh the costs.</p> <p>The Division believes that providing injured workers with a minimal level of basic information concerning the three most important benefits will improve the quality of communication between injured workers and claims administrators, and reduce friction and miscommunications - which may result in a decrease in disputes requiring resolution through litigation.</p>	

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>program to provide information and assistance concerning the rights, benefits, and obligations of the workers' compensation law to employees and employers subject thereto. The program shall include, but not be limited to, the following:</p> <p>(1) The preparation, publishing, and as necessary, updating, of guides to the California workers' compensation system for employees and employers. The guides shall detail, in easily understandable language, the rights and obligations of employees and employers, the procedures for obtaining benefits, and the means provided for resolving disputes. Separate guides may be prepared for employees and employers. The appropriate guide shall be provided to all labor and employer organizations known to the administrative director, and to any other person upon request.</p> <p>(2) The preparation, publishing, and as necessary, updating, of a pamphlet advising injured workers of their basic rights under workers' compensation law, and informing them of rights under the Americans with Disabilities Act, and the provisions of the Fair Employment and Housing Act relating to individuals with a disability. The pamphlet shall be written in easily understandable language. The pamphlet shall be available in both</p>			

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>English and Spanish, and shall include basic information concerning the circumstances under which injured employees are entitled to the various types of workers' compensation benefits, the protections against discrimination because of an injury, the procedures for resolving any disputes which arise, and the right to seek information and advice from an information and assistance officer or an attorney.</p> <p>...</p> <p>(c) Each information and assistance officer shall be responsible for the performance of the following duties:</p> <p>(1) Providing continuing information concerning rights, benefits, and obligations under workers' compensation laws to injured workers, employers, lien claimants, and other interested parties.</p> <p>...</p> <p>(3) Distributing any information pamphlets in English and Spanish as are prepared and approved by the administrative director to all inquiring injured workers and any other parties that may request copies of these pamphlets.</p> <p>Until the enactment of AB 749 in 2002, Labor Code section 138.4 required that for lost time claims, claims administrators were to include with the first notice of payment or notice of delay in payment a pamphlet published or</p>			

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>approved by the AD that advised injured workers of their benefits, rights, and obligations under workers' compensation laws. Prior to the drafting of AB 749, CHSWC recommended that the Legislature revise LC Section 138.4 to require claims administrators to include its comprehensive guide (from which the fact sheets were taken) with the first notice of payment, notice of delay in payment, notice of nonpayment or notice of rejection of any liability.</p> <p><u>Rejected by the Legislature:</u> By enacting AB 749, the Legislature flatly rejected that recommendation by deleting Labor Code section 138.4 entirely. Instead, they opted for a streamlined process by amending Labor Code section 5401 to require that the information from the pamphlet be incorporated into the DWC-1 Claim Form and Notice of Potential Eligibility. Thus, that information is now provided to injured workers as a tear-off cover sheet attached to the DWC-1 claim form, which is given to them at the time their injury is reported. The Notice of Potential Eligibility also tells workers how to obtain additional information.</p> <p>The issue of requiring a comprehensive guide for injured workers was revisited in 2004 when it was included in early drafts of SB 899, but it was again rejected by the Legislature. The AD cannot do by regulation what the statute does not permit and what the Legislature has specifically rejected.</p> <p><u>Statutory Authority:</u> The new proposed</p>			

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>regulations continue to require the use of specific fact sheets in addition to the benefit notices. While the statute requires claims administrators to provide certain specific information to injured workers, nothing in the statutory authority cited by the AD authorizes the use of these fact sheets for that purpose. The fact sheets are not a part of the regulation and have never been noticed for or subject to a regulatory hearing.</p> <p>The Institute's members are concerned that by including these materials by reference, the Division could, without notice or a public hearing, modify fact sheets, add additional fact sheets, require the regulated community to provide new informational materials, or require the delivery of the comprehensive guideline created by the LOHP and the Commission on Health and Safety and Workers' Compensation several years ago – the guideline that has been specifically rejected by the Legislature twice before.</p> <p><b>Necessity</b> Government Code section 11349(a) states:</p> <p>"Necessity" means the record of the rulemaking proceeding demonstrates by substantial evidence the need for a regulation taking into account the totality of the record. For purposes of this standard, evidence includes, but is not limited to, facts, studies, and expert opinion.</p> <p>The AD proposes the use of the Fact Sheets</p>		<p>This portion of the comment constitutes a general objection to the adoption of the regulations based on conclusory allegations of failure to meet APA standards and questioning the need for the regulations. The comment does not make recommendations or objections addressing any specific sections of the regulations. Generalized objections such as this one do not require specific responses pursuant to</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>without an adequate rationale, saying repeatedly in the statement of reasons that the addition of the Fact Sheets “is necessary to ensure that all injured workers are provided with a minimum level of basic information about potential benefits ... ” in light of the recent legislative changes. The benefit notice regulations accomplish exactly that goal without the use of the Fact Sheets.</p> <p>The Institute views the use of the Fact Sheets as unnecessary, redundant, and inapposite to the goal of informing injured workers. The Division offers no evidence, analysis, or expert opinion to support this change. The AD imposes additional notice requirements that are not supported by the statutory references and shifts the informational burden of the Division to claims administrators in violation of section 139.6, based only upon a bare, unsupported assertion of authority.</p> <p>The Institute believes that the AD has failed to meet the dictates of Government Code section 11349(a) and that the proposed regulation is, therefore, invalid. No regulation is valid or effective unless consistent with and not in conflict with statute and is reasonably necessary to effectuate purpose of statute. <u>Rosas v. Montgomery</u> (1970) 88 CR 907, 10 Cal.App.3d 77.</p> <p><u>Benefit Notice Program</u>: The use of fact sheets is poor policy for more practical reasons. The benefit notices approved by the AD are legal documents tailored to very specific rights and statutory obligations. When</p>		Government Code §11346.9(a)(3).	

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the procedures are followed, the benefit notices have legal consequences: the right to medical care can be terminated, TD and PD benefits can be modified, and the injured employee's right to return to work can be affected.</p> <p>Part of the legislative debate in 2002 and 2004 over the use of the "Workers' Compensation In California, A Guidebook for Injured Workers" created by the Commission on Health and Safety and Workers' Compensation was the fact that any kind of material like this becomes obsolete so quickly. There is nothing in the proposed regulations that would ensure that the information in these Fact Sheets would be routinely maintained. This raises the risk that duplicate notices would be overlapping, contradictory, and confusing for injured employees. The addition of the Fact Sheets will not only add cost to an already burdensome program, but will likely interfere with the automated benefit notice systems in place now.</p> <p>Even though revised in December 2005, each Fact Sheet contains the following disclaimer:</p> <p style="padding-left: 40px;">"The information contained in this fact sheet is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different from those presented here."</p> <p>With the ongoing regulatory changes in</p>		<p>The Administrative Director does not accept this comment. The fact sheets were designed to be individually and rapidly updated as necessary without the need for regulatory changes or revising and distributing a large guidebook.</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>California workers' compensation in 2005 and 2006, as well as a steady stream of changes brought about through case law, the fact sheets become obsolete, incorrect, incomplete, and misleading almost from the day they are published. No agency or entity has the resources to keep such information -- whether published as a guidebook or a series of "fact sheets" -- up to date.</p> <p>The Division has made the fact sheets general in nature, so general that their inclusion in the benefit notice program is inappropriate and potentially misleading. These materials can be distributed by the Division through the local appeals boards, union halls, schools, and public libraries but to mandate their inclusion along with specific benefit notices that affect legal rights and obligations is counterproductive and contrary to the goal of the benefit notice program.</p>			
Section 9812(a)(2)	<p><b>Recommendation</b></p> <p>The following language appears in proposed regulation section 9812(a)(2) and several other proposed regulations:</p> <p>(2) ... <del>The claims administrator shall send an additional notice or notices within 5 days after the determination date it specified, to advise of any further delay. If the claims administrator cannot make a determination by the date specified in a notice to the injured worker, the claims administrator shall send a subsequent delay notice to the injured worker, not later than the determination date specified in the previous delay notice, notifying the injured</del></p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	<p>The Administrative Director does not accept this comment.</p> <p>The existing regulations allow for a 5 day gap between when an injured worker was told to expect a determination, and when he or she is told that that determination will be delayed. This often results in phone calls to an adjuster, I &amp; A officer, or attorneys or the commencement of proceedings before the WCAB.</p>	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><u>worker of the revised date by which the claims administrator now expects the determination to be made.</u></p> <p>Wherever this revision appears, the new language should be deleted and the current language should be retained:</p> <p>(2) ... The claims administrator shall send an additional notice or notices within 5 days after the determination date it specified, to advise of any further delay.</p> <p><b>Discussion</b> While the goal of keeping the injured worker well informed is the essential purpose of the benefit notice program, the proposed regulations add a confusing revision where none is needed. The current regulation requires that when claims administrators do not have specific information, they should advise the injured worker and provide a date for further notification. The current language is sufficient, clear, and accomplishes the same goal. The proposed revision is ambiguous and convoluted. The Institute recommends no change in these areas.</p>			
Section 9767.16	<p><b>Recommendation</b> Several aspects of this new regulation are confusing. The regulation should make it clear that the rule applies only when an MPN is being terminated indefinitely without a substitute MPN. Other regulations cover changes to the MPN or the replacement of one network with a new MPN. To avoid confusing, overlapping notices, the purpose of this notice should be clearly stated.</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director</p>	<p>The Administrative Director accepts this comment in part. The regulation will be clarified to accurately reflect the Administrative Director's broader intent to apply this regulation to the situation where there will be a transition from one MPN to another.</p>	<p>Amended language has been distributed for public comment.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<b>Timing</b> In the preamble to subsection (a), the covered employee must be given “not less than 45 calendar days’ written notice” while in subsection (e) the Division is to have notice “not less than 30 calendar days.” There will be circumstances where these time limits will not be possible to meet. It is suggested that the stated time be 30 calendar days for both when the termination date is known and a reasonable time after the employer or insurer becomes aware that the MPN will cease doing business.	California Workers’ Compensation Institute December 12, 2006 Written Comments	The Administrative Director accepts this portion of the comment. The regulation will be changed to require 45 days notice to DWC and 30 days notice to the employee. DWC approval of the change must be obtained before an employee may be notified.	Amended language has been distributed for public comment.
Section 9767.16(b)	<b>Recommendation</b> In subsection (b) there is the requirement that “every employee” be advised that “any covered employee” will be free to select a new treating physician. The termination of the medical network will only affect employees covered by the network, so it seems unnecessary to notify every employee.	Robert E. Young Communications Director  Michael McClain General Counsel & Vice President  Brenda Ramirez Medical and Claims Director California Workers’ Compensation Institute December 12, 2006 Written Comments	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9767.16(c)(1)	<b>Recommendation</b> (1) If it is the employer, <u>as defined in Labor Code section 4616.5</u> , that terminates or otherwise ceases use of the MPN, the employer shall advise every covered employee of the insurer’s liability for continuing care for ongoing claims, and the potential penalties that may be imposed by the WCAB for unreasonable delay or interruption	Robert E. Young Communications Director  Michael McClain General Counsel & Vice President  Brenda Ramirez Medical and Claims	The Administrative Director does not accept this comment. Because both self-insured employers and insurers can be MPN Applicants, either can terminate the MPN and whichever does would then be responsible for giving proper notice to employees.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>of that care.</p> <p><b>Discussion</b> Only an employer as defined in section 4616.5 has the authority to create or contract for the services of an MPN and, therefore, only that employer would have the right to terminate the network.</p> <p>An insurer covers an employer for all the consequences of industrial injuries during the policy period and will continue to be liable for claims that arise during that period. There will be no interruption in treatment for those workers already receiving medical care through the insurer's MPN, as it will not be terminated when the employer changes coverage, no matter how that happens. To the extent that this is not clear in subdivision (c)(1), then the notice will be misleading.</p>	<p>Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>		
Section 9810(a)	<p><b>Recommendation</b> The proposed regulations call for an effective date of 60 days after the filing with the Secretary of State. If the AD proceeds with the wide-ranging revisions dictated in the proposed regulations, claims administrators will have to revamp their entire notice program and revise the automated systems extensively. The Institute recommends a 120-day implementation schedule.</p> <p><b>Discussion</b> Because changes to the benefit notice program would require costly and extensive reprogramming, the Institute has recommended that the AD avoid any changes to the benefit notice program unless absolutely</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	The Administrative Director accepts this comment and will extend the effective date until 120 days after filing with the Secretary of State.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	required by the new statutes. If the AD imposes these new requirements, however, then the deadline for implementation must be extended. Some of the proposed attachments (Fact Sheets) may require the development of manual processes to compliment the automated systems. The regulated community needs sufficient time to implement the changes efficiently.			
Section 9810(i)	<p><b>Recommendation</b> The proposed regulations should clearly state that the AD will provide Spanish language versions of the required notices that comply with all aspects of the notice regulations.</p> <p><b>Discussion</b> Requiring all benefit notices to be provided in English and Spanish is an unprecedented and an exponential increase in the burden of the program. While the Division has offered English language versions of the benefit notices, required language, and fact sheets, there are no Spanish language versions available. The dictates of the proposed regulations cannot be met until the Division provides the appropriate translation.</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	The Administrative Director does not accept this comment. The proposed regulations provide required content in most cases and do not require mandatory notice language – leaving it up to the claims administrator to draft the actual notice. This is intended to give claims administrators flexibility.	None.
Section 9811(e)	<p><b>Recommendation</b> Eliminate the expansion of the remedies notices and retain the current language.</p> <p><b>Discussion</b> The Labor Code already provides for notices of the employee's remedies in those circumstances where a dispute is likely. Here, the AD is mandating that such language be provided in every benefit notice. Instead of focusing on providing relevant information</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers'</p>	The Administrative Director does not accept this comment. The workers' compensation system has become more complex since the benefit notice regulations were last updated, and the percentage of unrepresented injured workers has increased. For these reasons, the Administrative Director has determined that the notice of rights to disagree with their claims administrator's actions should	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>when it is needed, the AD is requiring that all injured workers get information that only a few may ever use. Of the roughly 600,000 claims filed every year, 70% of those are medical only claims, which are uncomplicated and resolve promptly.</p> <p>The only rationale provided for this inordinate expansion of the remedies notices was the comment in the statement of reasons that these notices are “necessary to improve the quality of the information given to injured workers,” to encourage communication, and to advise employees that ADR programs may have different remedies available. But the potential for confusion due to over-communication of irrelevant, boilerplate information was one of the primary reasons that the Legislature refused to accept the mandatory use of the comprehensive workers’ compensation guide in the past. Such an over-use of the remedies notice will only communicate to injured workers that they need legal counsel in every instance in order to receive the compensation they are due. The Legislature has never mandated this level of notification and, as we have previously noted, it has been specifically rejected twice in the recent past.</p>	<p>Compensation Institute December 12, 2006 Written Comments</p>	<p>be required uniformly on all benefit notices.</p>	
<p>Section 9812(g)(2) and (3)</p>	<p><b>Recommendation</b> The required reports referred to in subdivision (g) should be eliminated.</p> <p><b>Discussion</b> This regulation requires that the claims administrator provide the medical report on which the determination of permanent disability was based or supporting the</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims</p>	<p>The Administrative Director does not accept this comment. Providing a copy of the medical report along with the relevant benefit notice and any informative pamphlet(s) to an injured worker will enable them to make a more informed choice as to how to proceed with their claim.</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	determination that there is no permanent disability. Labor Code section 4061(a)(1) requires only a notice to that effect, and CCR section 9810(d) requires only that a claims administrator make available to the employee upon request copies of medical reports except for psychiatric reports that the physician recommended against providing.	Director California Workers' Compensation Institute December 12, 2006 Written Comments		
Section 9812(g)(3)(C)	<p><b>Recommendation</b> The regulation should be eliminated.</p> <p><b>Discussion</b> The claims administrator will not request a rating from the DEU when there is no PD found in a medical report, therefore this regulation is unnecessary.</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	The Administrative Director does not accept this comment. It has been the experience of the Disability Evaluation Unit that many claims administrators will request a "zero" rating from the DEU for use in settlement negotiations.	None.
Section 9812(g)(4)	<p><b>Recommendation</b> For injuries occurring on or after January 1, 2005, the claims administrator shall, concurrently with any increased or decreased payment, notify the injured worker of any increase or decrease in the amount of the injured worker's permanent disability payments, pursuant to Labor Code section 4658, subdivision (d) resulting from the employer's offer of regular, modified or alternative work and acceptance by the injured worker; or resulting from the employer's failure to offer, or the employer's early termination of, or the injured worker's refusal</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>to accept the employer's offer of, regular, modified or alternative work. The information required by this subdivision shall be given in the appropriate PD payment start notice, PD payment resumption notice or notice of change in rate, payment amount or payment schedule.</p> <p><b>Discussion</b> The PD adjustment established in the statute is not dependent on whether or not the injured employee accepts or refuses the offered work. The AD has no authority to modify this statutory requirement and the notice should be clear on that point.</p>			
Section 9812(i) and 9812(j)(2)	<p><b>Recommendation</b> Delete the section 5402(c) language from subsection (i). Delete or revise the section 5402(c) language from subsection (j).</p> <p><b>Discussion</b> Labor Code Section 5402(c) states:</p> <p>(c) Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	<p>The Administrative Director does not accept this comment.</p> <p>The employer is responsible for this benefit until the date the claim is denied.</p> <p>This regulation merely requires that the claims administrator provide a minimum amount of mandatory information concerning an employee's potential entitlement to the benefit. The claims administrator is free to draft its actual notices to include an advisement to the injured worker that filing a claim form is a precondition to entitlement to this benefit.</p>	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>The 5402(c) language is appropriate for the delay notice, as the statutory conditions will be met, but a clarification is required with regard to the denial notice. For claims reported after the effective date of the statute, the claims administrator should advise the employee to refer medical bills, if the employee has filed a claim form. Medical services incurred between the filing of the claim form and the date of claim denial may be the liability of the claims administrator up to the statutory maximum -- \$10,000.</p> <p>These notices must be broadened in order not to mislead the injured employees. The proposed regulations create notices that are simplistic and miss conditions that will affect the employee's right to reimbursement, including reference to the limitations contained in section 5307.27, employment issues, and coverage questions. More importantly, the medical authorization is not triggered until the employee returns the claim form to the employer. The notice implies that the injured worker need only send in their medical bills and they will be paid subject to the \$10,000 limit.</p>			
Section 9812(j)(2)	<p><b>Recommendation</b> For claims reported on or after April 19, 2004, regardless of the date of injury, if the claims administrator sends a notice of delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that Labor Code section 5402(c) provides that within one working day after an employee files a claim form, the employer</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims</p>	<p>The Administrative Director does not accept this comment.</p> <p>This regulation merely requires that the claims administrator provide a minimum amount of mandatory information concerning an employee's potential entitlement to the benefit. The claims administrator</p>	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).</p> <p><b>Discussion</b> These revisions must be made in order to clarify the parameters of this reimbursement.</p>	<p>Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	<p>is free to draft its actual notices to include an advisement to the injured worker that filing a claim form is a precondition to entitlement to this benefit.</p>	
Section 9813(c)(2)(G)(2)	<p><b>Recommendation</b> "The notice shall include a DWC Form RU 103 ..."</p> <p><b>Discussion</b> There appears to be a missing word.</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	<p>The Administrative Director accepts this comment and thanks the commenter for pointing out a longstanding typographical error in the regulations.</p>	<p>Amended language has been distributed for public comment.</p>
Section 9813.1(1)	<p><b>Recommendation</b> 9813.1(1) is an unnecessary duplication of the notice requirements already contained in the SJDB regulations. This section should be deleted.</p> <p><b>Discussion</b> Article 7.5 provides all necessary notices and forms relating to job offers and any additional requirements contained in this section are redundant and unnecessary.</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers'</p>	<p>The Administrative Director does not accept this comment. The Administrative Director's intent is to have references to all benefit notices in these regulations.</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
		Compensation Institute December 12, 2006 Written Comments		
Section 9813.1(2)	<b>Recommendation</b> The subsection notes the requirements of CCR section 10002 and is unnecessary and redundant.	Robert E. Young Communications Director  Michael McClain General Counsel & Vice President  Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9813.1(3)	<b>Recommendation</b> Delete this subdivision. If this subsection is not deleted, eliminate subsection (4), as it can be combined with subsection (3).  (3) Notice of Modified <u>or Alternative</u> Work, (where the injured worker is unable to return to <del>their</del> his or her usual <u>occupation and customary job or the position held at the time of injury</u> ). Within 30 days of the termination of temporary disability indemnity payments, the employer may offer, <del>in the form and manner prescribed by</del> <u>on the mandatory notice of offer of modified or alternative work set forth in</u> section 10133.53 of these regulations, modified <u>or alternative</u> work accommodating the employee's work restrictions, lasting at least 12 months.  <b>Discussion</b>	Robert E. Young Communications Director  Michael McClain General Counsel & Vice President  Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	The notice requirements for the offer of modified or alternative work are already set forth in the SJDB regulations and are complete and very specific.			
Section 9813.1 – Form 10133.53	<p><b>Recommendation</b> This paragraph directs the claims administrator to include a dispute resolution form along with the Notice of Modified or Alternative Work for injuries occurring on or after January 1, 2004. The paragraph should be deleted as it imposes additional requirements to perfect the offer of modified or alternative work, which is governed by another set of regulations that have not been noticed for revision. The entire paragraph is unrelated to the benefit notice program and should be eliminated.</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9813.1 – Dispute Resolution	<p><b>Recommendation</b> The final paragraph of this subsection should be deleted.</p> <p><b>Discussion</b> The Division is requiring that a "Request for Dispute Resolution" (Form DWC-AD 10133.55) be sent with the mandatory form "Notice of Modified or Alternative Work" (Form DWC-AD 10133.53). There is no requirement in the regulations (or, statute) to include a Dispute Resolution form when sending out a Notice of Modified or Alternative Work form. Labor Code Section 4658.6 is clear that the employee's failure to respond to a legitimate offer of work is sufficient, alone, to terminate the employer's liability for the supplemental job displacement benefit. The regulation seems to impose</p>	<p>Robert E. Young Communications Director</p> <p>Michael McClain General Counsel &amp; Vice President</p> <p>Brenda Ramirez Medical and Claims Director California Workers' Compensation Institute December 12, 2006 Written Comments</p>	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.



BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the exact wording to be used in such notices. Ideally, any such notices should be drafted so that the claims administrator and/or employer can draft using English and be readable to the other party in English or Spanish.		Spanish language.	
Section 9810	Commenter is concerned that the Spanish language requirement will create an undue hardship on the part of claims administrators. Many of the notices require free form drafting and, to be able to provide all notices required by Section 9810 in English and Spanish, claims administrators may be forced to hire additional personnel. Prior to implementation of any foreign language requirement, the commenter requests the Division provide exact foreign language wording required along with the corresponding English translation.	Stewart J. Brooker Associate Counsel CNA December 11, 2006 Written Comment	The Administrative Director does not accept his comment. This requirement is consistent with the legislative intent expressed in Labor Code 124(b) that Spanish speaking employees receive notices in the Spanish language. As the overwhelming volume of employee notices are sent by claims administrators, not the Division, requiring these notices to be made available in Spanish is a rational implementation of the Legislature's intent.	None
Fact Sheets	Commenter is concerned that the requirement that the fact sheets be served with notices creates an additional cost requirement for insurers, may provide information not applicable to the recipient's injury, and may become outdated as laws and regulations change. Ensuring the proper fact sheet goes out with the correct corresponding notice will be costly in terms of reprogramming of automated mailing systems and, depending on the implementation date, and may require the hiring of additional personnel to manually process mailings until such time as systems can be reprogrammed or purchased to provide for an automated process. In fact, by the time some insurers are able to reprogram their systems to automate the fact sheet	Stewart J. Brooker Associate Counsel CNA December 11, 2006 Written Comment	The Administrative Director does not accept this comment. The Administrative Director has the authority and discretion to prescribe reasonable benefit notice requirements. The Division believes that the benefits of the proposed requirement to provide injured workers with informative pamphlets concerning temporary disability benefits, permanent disability benefits or the Agreed Medical Evaluator/Qualified Medical Evaluator ("AME/QME") medical evaluation process outweigh the costs.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	coordination and mailing, laws may have changed to make the information in the fact sheets outdated.		The Division believes that providing injured workers with a minimal level of basic information concerning the three most important benefits will improve the quality of communication between injured workers and claims administrators, and reduce friction and miscommunications - which may result in a decrease in disputes requiring resolution through litigation.	
Section 9811(e)	<p>Commenter believes that the employee remedy language is not required in start notices for TD, PD, VRMA and death benefits.</p> <p>Commenter thinks that the Steven Peace language concerning awards is inappropriate unless the claim involves PD, is delayed or is denied.</p> <p>The rationale is that even though benefits are being provided accurately and timely, the notice advises unrepresented employees to seek legal counsel before the claims administrator may have the opportunity to address or correct a potential error that the employee can bring to the claims administrator's attention after receiving the notice.</p>	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director does not accept this comment. The workers' compensation system has become more complex since the benefit notice regulations were last updated, and the percentage of unrepresented injured workers has increased. For these reasons, the Administrative Director has determined that the notice of rights to disagree with their claims administrator's actions should be required uniformly on all benefit notices, including those issued in death claims.	None.
Section 9812(a)(2)	<p>The proposed regulation says the parties "may" obtain or be asked to attend a PQME evaluation, but the panel request form "shall" be attached to the notice.</p> <p>Where the reason for the TD delay is that the</p>	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director does not accept this comment. Temporary disability would only be payable if authorized by the primary treating physician. If there was no such authorization, TD would be denied.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	PTP hasn't authorized TD, it's inappropriate to require the parties to use the PQME/AME process to resolve the issue. The claims administrator should have the option, but not be required, to send the panel form when sending the form creates more confusion and acts to delay resolution of the issue.			
Section 9812(a)(3)	Here the reason to use the PQME/AME evaluation is when TD was denied.  If the TD denial is based on the AME/PQME opinion, then sending the panel form is inappropriate to resolve the issue.	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9812(a)(2) and (a)(3)	The wording of the notice about the PQME/AME process, and whether the panel request form must be attached, should be left to the discretion of the claims administrator as dictated by the circumstances of the claim.	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director does not accept the first portion of this comment. The actual wording of the notice is left to the claims administrator's discretion.  As to the second portion of this comment, the Administrative Director accepted this comment and responded to it in the comment immediately above.	None.
Section 9812 (e) and (f)	Claims regardless of date of injury are to be resolved using the PQME/AME process for unrepresented employees, LC4062.1 and the AME/PQME process (either the former LC4062 or LC4062.2 for injuries on/after 1/1/05). Pre-1994 claims are now subject to the PQME/AME process to resolve. It appears that separate notices for injuries occurring prior to 1991, or between 1991 through 1993, are no longer necessary.  Rather, it may be necessary to have separate notices for injuries prior to 2005 and for those	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director accepts this comment as to § 9812, subdivisions (f) and (g). (The reference to subdivision (e) appears to have been intended to refer to these subdivisions, not subdivision (e).)	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	occurring on/after 1.1.05, if only to explain the two-tiered PD process, or Labor Code 4656(d).			
Section 9812(f)(4)	<p>The added QME language used here allows claims administrators the necessary flexibility to send PQME/AME information and the QME panel request form only when needed.</p> <p>The insertion of similar language elsewhere in the regulations should follow this model. Otherwise, claims administrators will be forced to offer the QME panel option when it's not required by statute, leading to more confusion, delays and potential litigation.</p> <p>A case in point is CCR9812(g)(2), where it is premature to offer a panel within 14 days of the end of TD and the person is not yet P&amp;S, which is more often the case when the end TD notice is sent.</p> <p>Another case in point is CCR9812(g)(2)(A). Where the person was evaluated by a PQME to determine compensability under LC4060, it is inappropriate to require the claims administrator to provide a PQME request form at the time the person becomes P&amp;S. To do so contradicts the DWC procedure requiring that the employee return to the same PQME physician who previously evaluated the person for the same or previous injuries whenever possible.</p> <p>The proposed regulations should provide common-sense procedures to deal with such scenarios. Commenter suggests that the provision of the PQME request form be made</p>	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director accepted these comments and responded to them in earlier comments on these subdivisions.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	contingent upon whether the panel request form was sent previously, or an AME evaluation was previously used on the claim to resolve issues. It's not an ideal solution, but better.			
Section 9812(g)(4)	<p>Proposed language states that the claims administrator should notify the person of an increase or decrease in weekly PD rate based on factors to include the injured worker's refusal to accept the employer's job offer.</p> <p>Pursuant to LC4658(d)(3)(A), whether the employee accepts or rejects the offer is irrelevant. In fact, the regulation language makes it sound like an employee's refusal of a job offer will result in increased PD, which does not appear to be the intent of the statute. I suggest deletion of the phrase: "or the injured worker's refusal to accept the employer's offer of, (sic) regular, modified or alternative work."</p>	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director accepts this comment, and will incorporate the revised language suggested by the State Compensation Insurance Fund in its December 12, 2006 comment.	Amended language has been distributed for public comment.
Section 9812(i)	The regulations should make clear that employers should not be required to put lien parties on notice of the denial where the \$10,000 cap of medical expenses is exhausted.	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	The Administrative Director does not accept this comment. The notice requirement for lien claimants in this subdivision does not apply to treatment under Labor Code §5402(c) – only to lien claims under the referenced Labor Code sections.	None.
Section 9812(j)	LC4060(c) and (d) state that "If a medical evaluation is required to determine compensability at any time after the claim form is filed... "a medical evaluation shall be obtained to determine compensability: (c) sets forth the procedures for represented employees, (d) for unrepresented. The statute does not require that a medical evaluation process be used where a medical evaluation is	Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment	<p>The Administrative Director does not accept this comment. There is nothing in the proposed regulations that would require doing what the comment objects to.</p> <p>The only requirement being adopted is to send the injured worker an informational pamphlet explaining</p>	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>NOT required to determine compensability.</p> <p>Factual and legal questions that do not require a medical evaluation to resolve include:</p> <ol style="list-style-type: none"> <li>1. the person was not an employee of the employer at the time of injury.</li> <li>2. the injury did not occur in the course of employment (e.g. going and coming rule cases).</li> <li>3. the insurer in question did not provide workers' compensation coverage for an employer at the time the employee's injury occurred.</li> <li>4. a specific injury is barred by the statute of limitations.</li> </ol> <p>It is not appropriate to require that a PQME request form be sent to unrepresented workers, or that the claims administrator attempt to agree to an AME, when a medical evaluation will not resolve the factual or legal question of compensability.</p> <p>Commenter agrees that many factual situations require a medical evaluation to resolve, such as CT claims and/or stress claims (per the Rolda decision), but not all do. The claims administrator should be allowed the flexibility to exercise discretion as indicated.</p>		<p>what to do if the injured worker disagrees with the QME.</p>	
Section 9813(a)(3)	<p>This proposed regulation states that a PQME request form must be sent where VRMA is denied because the employee is not medically eligible to be a QIW. It is inappropriate to require a claims administrator to follow this procedure when the decision to deny VRMA</p>	<p>Carolyn Bradford Sr. Program Analyst Octagon Risk Services December 12, 2006 Written Comment</p>	<p>The Administrative Director does not accept this comment. There is nothing in the proposed amended regulations that would require doing what the comment objects to.</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	is based on the medical opinion of a PQME/AME physician. The proposed regulation should allow flexibility to not request a PQME/AME in such a scenario.		The only requirement being adopted is to send the injured worker an informational pamphlet explaining what to do if the injured worker disagrees with the QME.	
Section 9767.16(b)	<p><b>9767.16(b)</b> addresses the content to be included in the notice to each covered employee. In the medical provider network (MPN) definitions, “covered employee” includes former employees when the employer has ongoing workers' compensation obligations. The proposed regulation language can be misleading to “covered employees” who are former employees with on-going medical treatment because it implies s/he is not subject to their new employer’s options of medical control. Under LC §4600, the subsequent employer can exercise medical control either through the use of an MPN or thirty day medical control for new industrial injuries or illnesses.</p> <p>For clarity, the use of <i>current physician</i> should be replaced with the injured employee’s “primary treating physician” defined in 8CCR §9767.1.</p> <p><b><u>Recommendation:</u></b> Commenter recommends the following amended language:</p> <p>(b) The notice shall also advise every employee that any covered employee with a new industrial injury or illness occurring on or after the effective date of</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	<p>The Administrative Director does not accept this comment. This provision will not be changed. It is not limited to an employee’s “primary treating physician” and is intended to include specialists with whom the employee is treating.</p> <p>An additional provision to cover former employees is not necessary</p>	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>termination or cessation of use of the MPN, will be free to either continue with his or her <del>current</del> <u>primary treating</u> physician or to select a physician, pursuant to Labor Code § 4600, 30 days after the date the employee reported his or her injury.</p> <p>Commenter recommends that a new subsection address “covered employees” who are former employees and their rights upon a new industrial injury or illness. The proposed section (b) suggests these former employees may not be subject to their new employer’s MPN (if applicable).</p>		due to the clarification of §9767.16(b).	
Section 9810(a)	<p><b>§9810 (a)</b> addresses when the regulations shall become effective. Implementation will involve updating existing benefit notices, Fact Sheets, attachments, updating electronic systems and training staff. Further, if adoption of the proposed regulation to provide notices in Spanish occurs, additional time will be necessary to translate all benefit notices and train staff who write in Spanish in order to implement this new process. Two (2) months is insufficient time to meet these requirements. State Fund recommends extending the proposed language to become effective 120 days after the date of filing with the Secretary of State.</p> <p><b><u>Recommendation:</u></b></p> <p>Commenter recommends amending the</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director accepts this comment and will extend the effective date until 120 days after filing with the Secretary of State.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>proposed language and offers the following:</p> <p>§9810 (a) This Article applies to benefit notices prepared on or after its effective date. Amendments to this Article filed with the Secretary of State in January, 1994 on (OAL TO INSERT THE DATE OF FILING WITH SECRETARY OF STATE HERE) shall become effective for notices required to be sent on or after April 1, 1994 (OAL TO INSERT A DATE <del>60-120</del> DAYS AFTER THE DATE OF FILING WITH SECRETARY OF STATE HERE).</p>			
Section 9810(b)	<p><b>§9810 (b)</b> allows the Administrative Director (AD) to issue and revise the Benefit Notice Instruction Manual from “time to time.” Claims administrators are required to issue notices properly and timely; failure to do so will result in administrative penalties assessed by DWC’s Audit Unit. DWC should issue a revised benefit notice manual each time there is a regulatory change. This will provide the workers’ compensation industry clear direction on benefit notice delivery to injured employees. Further, the manual revision should coincide with the regulatory changes.</p> <p><b><u>Recommendation:</u></b> Commenter recommends amending the proposed language and offers the following: “The Administrative Director <del>may</del>,</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director does not accept this comment. While the Administrative Director intends to update the benefit notice manual whenever significant substantive revisions are made to the benefit notice regulations, there may be occasions when the Administrative Director is unable to make these revisions available at the time the proposed regulations are filed with the Secretary of State.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<del>at his or her discretion, shall</del> issue and revise <del>from time to time a</del> the Benefit Notice Instruction Manual as a guide for completing and serving the notices required by this Article <u>at the time of filing with the Secretary of State.</u>			
Section 9810(c)	<p><b>§9810 (c)</b> addresses the content and formatting of benefit notice letters. This section proposes inclusion of the claims administrators address and phone number on the notice, as well as the phone number and address of the person responsible for the payment and adjusting of the claim. Requiring two separate addresses and phone numbers may confuse injured employees and employers as to who and where they should be making contact.</p> <p>Several claims administrators are regionalizing certain aspects of the claims process, such as printing of the benefit notices, and routing mail to a centralized location while the actual claims adjusting is handled in a local district office. If the intent is to provide a means for the injured employee to contact the claims adjuster/representative, the proposed regulation's inclusion of the word "mailing" address will satisfy the intent and address the regionalization of claims administrators.</p> <p>Commenter recommends amending the proposed regulation to read as follows:</p> <p>“..excepting those mandatory</p>	<p>Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment</p>	<p>The Administrative Director accepts this comment in part and will allow the claims administrator to only provide its mailing address.</p>	<p>Amended language has been distributed for public comment.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>notices set forth in statute or where a specific notice form has been adopted as a regulation, may be produced on the claims administrator's letterhead. The notice letters shall identify <del>the claims administrator's name, address and telephone number,</del> the employee's name, employer's name, the claim number, the date the notice was sent to the employee, and the date of injury. All notices shall clearly identify the name and telephone number and mailing address of the <del>person</del>-individual claims examiner responsible for the payment and adjusting of the claim, <del>and shall</del> include a notation if one or more attachments are being sent with the notice, and shall clearly state that additional information may be obtained ...”</p>			
Section 9810(i)	<p><b><u>§9810 (i)</u></b> will require that all benefit notices shall be made available in English and Spanish. Commenter acknowledges the dilemma the DWC faces in administering and regulating a benefit notice delivery program in an environment of multicultural workers, many of whom are not versed in the English language. Merely requiring claims administrators to make available notices in English and Spanish will not satisfy the needs of workers in California. This topic should be addressed as a public policy issue.</p>	<p>Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment</p>	<p>The Administrative Director does not accept this comment. This requirement is consistent with the legislative intent expressed in Labor Code §124(b) that Spanish speaking employees receive notices in the Spanish language. As the overwhelming volume of employee notices are sent by claims administrators, not the Division, requiring these notices to be made available in Spanish is a rational implementation of the Legislature’s</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><b><u>Recommendation:</u></b> In lieu of the proposed regulations, commenter recommends opening communication between claims administrators and the DWC on this issue and offers the following for consideration and discussion:</p> <ul style="list-style-type: none"> <li>As opposed to providing the notice in Spanish, include an <i>assigned and required DWC letter number</i> on <i>each type</i> of benefit notice with a required statement at the end of the notice in Spanish directing the injured worker to the Information and Assistance (I&amp;A) Officers. <ul style="list-style-type: none"> <li>DWC has I &amp; A Officers at each location, a valuable resource. I&amp;A Officer would know by the DWC form numbers which notice the injured worker received and be able to assist.</li> </ul> </li> </ul> <p>Each benefit notice requires information specific to a particular benefit. Some necessitate communicating information that is not ‘mandatory language’ but required content. For example, all delay notices require a reason and determination date; a denial notice requires a reason for the denial; and, each time a benefit ends, a reason has to be provided by the adjuster.</p> <p>The proposed regulation does not appear consistent with several existing statutes. LC §124(b) places the responsibility to provide notices in Spanish and English on the</p>		intent.	

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>“Division” not claims administrators. LC §138.4(c) requires the Administrative Director to create reasonable regulations. To make notices available in both Spanish and English will be costly by requiring claims administrators to:</p> <ul style="list-style-type: none"> <li>• have staff who write in Spanish for reasons required in notices,</li> <li>• implement system programming and enhancement,</li> <li>• adjust work-flow processes, and</li> <li>• develop a method to distinguish when the claim involves an employee whose primary language is Spanish and avoid the appearance of ‘racial profiling’.</li> </ul> <p>In addition, some statutes require <b>mandatory</b> language be included in the benefit notice exactly as written. For example, LC §4061 states the verbiage in English to be provided in the letter. The statute did not indicate the mandatory language could be provided in any other manner than as dictated.</p>		<p>The Administrative Director does not accept this comment. Section 9810(i) would require all benefit notices, including those where the precise notice language is prescribed by statute or regulation, to be made available in Spanish.</p>	None.
Section 9811(a)	<p><b>§9811 (a)</b> defines Claims Administrator. The proposed language includes alternative dispute resolutions (ADR) programs/statutes currently in place. If subsequent legislation allows additional carve-out systems for delivering workers’ compensation benefits, the proposed regulations may not apply to any new ADR programs.</p> <p><b><u>Recommendation:</u></b> Commenter recommends regulatory language that allows for applicability to additional</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	<p>The Administrative Director does not accept this comment. The Division cannot draft its regulations on the basis of hypothetical future changes in statutes. If the ADR statutes are revised in the future, the Administrative Director will update the regulations as needed to accommodate these amendments.</p>	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	carve-out programs beyond existing statute. Subsequent regulatory sections addressing ADR need to reflect this flexibility.			
Section 9811(e)	<p><b>§9811 (f) (e)</b> provides the definition for “Employee’s (or claimant’s) remedies.” The proposed amendment of the definition requires that the employee’s remedies shall be included in “Every benefit notice, <i>excepting those mandatory notices set forth in statute</i> or where a specific notice form has been adopted as a regulation, shall include a mandatory statement of employee’s (or claimant’s) remedies:..” Based on LC §138.4(c), all benefit notices are required by statute. Based upon the proposed definition, the language for employee’s remedies would never be required. The proposed language does not appear to agree with the DWC’s regulatory intent.</p> <p><b><u>Recommendation:</u></b> Commenter recommends the definition be amended to reflect the intent of the DWC.</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director accepts this comment in part. The language quoted refers to notices that must be given using specific statutorily mandated language or a form. The benefit notices regulations do not create mandatory forms, they only mandate required content. The quoted language will be modified to improve its clarity.	Amended language has been distributed for public comment.
Section 9811(g)	<p><b>§9811 (h) (g)</b> provides the definition for ‘injury.’ The statement of reason states, “The proposed amendments will delete a redundant reference to “lost time beyond the date of injury” from the existing definition of “injury.” The existing definition for injury is “any injury as defined in LC §3208 which results in lost time beyond the date of injury, medical treatment beyond first aid, or death.” The proposed language modified the definition by changing the placement of the phrase “<u>lost time beyond the date of injury.</u>” This does not appear to delete any</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Initial Statement of Reasons misstated the rationale for this change. The actual intent was to re-order the phrases in terms of the logical order of escalating severity.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>redundancy.</p> <p><b><u>Recommendation:</u></b>  Commenter recommends that the existing language remain intact:  (g)"Injury" means any injury as defined in Labor Code Section 3208 which results in <i>lost time beyond the date of injury</i>, medical treatment beyond first aid, <del><i>lost time beyond the date of injury</i></del>, or death.</p>			
Section 9812(c)	<p><b>§9812</b> (c) addresses notices involving a Benefit Rate, <u>Payment Rate</u> or Schedule (TD, SC, PD, VRTD/VRMA) changes. Proposed language added the term “payment rate” in the notice title and used the term “payment amount” in the content.</p> <p><b><u>Recommendation:</u></b>  Commenter recommends the use of one term and offers the following;  (c) Notice of Changed Benefit Rate, Payment <del>Rate</del> <i>Amount</i> or Schedule (TD, SC, PD, VRTD/VRMA).  When the claims administrator changes the benefit rate, payment amount or benefit payment schedule for temporary disability indemnity, salary continuation, permanent disability indemnity...”</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9812(e) and (f)	<p><b><u>Permanent Disability Notices for Injuries Occurring Prior to 1991 through 1993.</u></b>  Benefit Notices that address injuries prior to 1994 should not be revised. Reformatting benefit notices for these dates of injury is a</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund	The Administrative Director does not accept this comment. Only claims administrators with open claims from this time period will be required to revise these notices. If a claims	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>costly and time consuming process. A regulation that will require amending notices for injuries that occurred over 10 years ago may not be in accordance with LC §138.4(c) as being necessary.</p> <p><b><u>Recommendation:</u></b>            Commenter recommends not changing the following sections:</p> <ul style="list-style-type: none"> <li>• 9812(e) Permanent Disability Notices prior to 1991</li> <li>• 9812(f) Permanent Disability Notices occurring in 1991, 1992, 1993</li> </ul>	December 12, 2006 Written Comment	administrator has open claims from this period, their benefit notices have to accurately advise an injured worker of the current law.	
Section 9812(g)(1)	<p><b><u>§9812(g) (1)</u></b> addresses the Delay in Permanent Disability. State Fund recommends omitting the proposed language, (C) “the need for continuing medical care” because this is not a reason to delay PD benefits.</p> <p><b><u>Recommendation:</u></b>            Commenter recommends the following:</p> <p>“If the claims administrator cannot make a determination of A) permanent and stationary status <i>and</i> B) the existence and extent of permanent impairment or limitations <i>and C) the need for continuing medical care ...</i>”</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director does not accept this comment. This provision concerns the monitoring of an unresolved need for treatment until the injured worker achieves <i>permanent and stationary</i> status – not permanent disability.	None.
Section 9812(g)(2)(B), (g)(2)(C), (g)(3)(B) and (g)(3)(C)	<p><b><u>§9812(g)(2)(B), (g)(2)(C), (g)(3)(B) and (g)(3)(C)</u></b> address permanent disability involving rating requests. State Fund recommends consistency when referring to</p>	Jose Ruiz Operations Claims Manager State Compensation	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the DWC Disability Evaluation Unit. These sections use the language “Disability Evaluation Unit”, “State of California Disability Evaluation Unit” and “DWC Disability Evaluation Unit.”</p> <p><b><u>Recommendation:</u></b> Commenter recommends using only one term.</p>	Insurance Fund December 12, 2006 Written Comment		
Section 9812(g)(4)	<p><b><u>§9812(g)(4)</u></b> addresses notice content for permanent disability indemnity payment when injury causes permanent disability. The proposed language “resulting from the employer’s offer...and acceptance by the injured worker...” and “or the injured worker’s refusal to accept the employer’s offer ...,” is not supported by statute. The “acceptance” and “the injured worker’s refusal” only affects the decrease adjustment in accordance with LC §4658(d). ”</p> <p><b><u>Recommendation:</u></b> Commenter recommends the following: For injuries occurring on or after January 1, 2005, the claims administrator shall, concurrently with any increased or decreased payment, notify the injured worker of any increase or decrease in the amount of the injured worker permanent disability payments, pursuant to Labor Code section 4658, subdivision (d) resulting from the employer’s offer of regular, modified or alternative work</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>regardless of whether the <del>and acceptance by the injured worker accepts or rejects the offer</del>, or resulting from the employer's failure to offer, <del>or the employer's early termination of, or the injured worker's refusal to accept the employer's offer of</del>, regular, modified or alternative work....”.</i></p>			
Section 9813.1	<p><b><u>§9813.1</u></b> addresses the Notice of Supplemental Job Displacement Benefit (SJDB), Offer of Regular, Modified or Alternative Work. Offer of “Regular” work is not required under the SJDB regulations, 8CCR §§10133.50 – 10133.60.</p> <p><b><u>Recommendation:</u></b> Commenter recommends omitting reference to “regular” work from the title of the section:</p> <p><b><u>§9813.1. Notice of Supplemental Job Displacement Benefit, Offer of Regular, Modified or Alternative Work. For Injuries Occurring on or after January 1, 2004.</u></b></p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9813.1(2)	<p><b><u>§9813.1(2)</u></b> requires providing the Notice of Regular Work under 8CCR § 10002. Return to Work regulations (8CCR §10002) do not apply to SJDB. Neither LC §§ 4658.5 nor 4658.6 require notices when the employee has returned to regular work.</p> <p><b><u>Recommendation:</u></b></p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter recommends deleting this entire section.</p> <p><u><del>Notice of Regular Work (where the injured worker is able to return to ...his or her usual and customary job). Within 30 days of the termination of temporary disability indemnity payments, the employer may offer, in the form and manner prescribed by section 10002 of these regulations, regular work, lasting at least 12 months.</del></u></p>			
Fact Sheet – Alternate Dispute Resolution	<p><b><u>Fact Sheets for Alternative Dispute Resolution Programs (ADR)</u></b> Regulations that require using the existing DWC Fact sheets will create confusion for injured employees who are participating in a carve-out program/ADR process.</p> <p><b><u>Recommendation:</u></b> Commenter recommends the DWC create Fact Sheets specific to and for use with benefit notices involving carve-out programs.</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	The Administrative Director does not accept this comment. Each individual ADR program may vary slightly.	None.
Section 9812(g)(4) Fact Sheet – Permanent Disability	<p><b><u>Permanent Disability Fact Sheet</u></b> The proposed regulation §9812(g)(4) will require claims administrators to include the “Permanent Disability Fact Sheet.” The Fact Sheet references LC § 4658(d)(2)(3)(4) Permanent Disability increase or decrease of payment. The increase or decrease applies to PD weekly payments and not the PD ‘Award’ as indicated. Also, the adjustment is based upon the employer’s offer of regular, modified or alternative work. Further, this statute applies only to injuries on or after January 1, 2005.</p>	Jose Ruiz Operations Claims Manager State Compensation Insurance Fund December 12, 2006 Written Comment	Although the Fact Sheets are not a part of the regulations, the Administrative Director appreciates being informed of this error in the fact sheet, and has corrected it.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><b><u>Recommendation:</u></b>  Committer recommends the following:  “ If you were injured on or after Jan. 1, 2005 your PD <del>award</del> <u>weekly payments</u> may be increased or decreased by 15 percent, depending on whether you work for an employer with 50 or more employees and your employer offers, fails to offer, or employer’s early termination of <del>and you accept or decline</del> regular, alternative or modified work.”</p>			
General Comment	<p>The proposed regulations fail to comply with the Government Code Section 11349.1 standards of necessity, authority, consistency, clarity and non-duplication. Additionally, this proposal will impose unneeded substantial additional costs and present implementation problems. Commenter believes this proposal is unnecessary and will result in imprecise and ineffective communications with injured workers. Commenter respectfully requests that the proposed regulations be withdrawn and rewritten to conform to current statutes and with a view toward accurate and precise information being provided in the notices.</p> <p><b>Costs and Purported Benefits of Notices</b>  In comments submitted on three different occasions in 2005, commenter emphasized that to serve their purpose, benefit notices should be accurate, complete, clear and concise. This proposal introduces new levels of complexity and cost for claims administrators without offsetting benefits to</p>	<p>Steven Suchil  Assistant Vice President  American Insurance Association  December 12, 2006  Written Comment</p>	<p>The comment constitutes a general objection to the adoption of the regulations based on conclusory allegations of failure to meet APA standards and questions the need for the regulations. The comment does not make recommendations or objections addressing any specific sections of the regulations. Generalized objections such as this one do not require specific responses pursuant to Government Code §11346.9(a)(3).</p>	<p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>injured workers, who have told us over the years that the sheer number of notices is confusing. If this proposal is adopted, injured workers will receive even more documents, and it will not result in more clarity of their rights and responsibilities, or as to the status of their claims.</p> <p>The Initial Statement of Reasons asserts that the proposal "will not have a significant adverse impact on business because the provision of timely and accurate notices to injured workers improves communications between injured workers and claims administrators, reduces confusion, and minimizes disputes and the litigation that can result from disputes."</p> <p>This is not accurate. The proposal will have significant impact - and costs - as claims administrators rush to reprogram entire automated benefit notice systems, which have been developed over time to assist with timely production of more than 100 variations on notices of all types. Claims administrators will have to figure out how to accommodate the attachment of the newly mandated fact sheets. Further, this proposal will not likely reduce litigation - the sheer profusion of additional documents and confusing information is likely to drive injured workers to seek professional legal advice.</p> <p><b>Necessity</b> Changes in law resulting from enactment of AB 227 in 2003 necessitated development of one new category of benefit notices - those</p>			

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	<p>related to the Supplemental Job Displacement Benefit (SJDB). The DWC addressed that need, comprehensively, in a rule that became effective on August 1, 2005. Anything more than a reference to Article 7.5, of Subchapter 1.5, of Chapter 4.5 is unnecessary. Reiteration of all the notice requirements would be redundant, and to the extent they are not identical, confusing.</p> <p>Changes in law resulting from enactment of SB 899 in 2004, specifically revision of the medical-legal process as well as authorization of the use of MPNs to provide medical treatment to injured workers, also necessitated revised or new notices. MPN notices are already prescribed in Section 9767.12 of Chapter 4.5 of Title 8, CCR, including 30 day prior notice to employees when the insurers' or self-insured employers' networks change.</p> <p>Revised benefit notices are required to reflect SB 899's amendments to the medical-legal process. New benefit notices may also be necessary for the unlikely eventuality that insurers decide to drop completely use of MPNs. But nothing else is required of the Administrative Director.</p> <p>The need for a complete overhaul and revision of the benefit notice program is neither required by statute nor justified by any evidence or supporting documentation, or provided in the initial statement of reasons, particularly in view of the costs that would be incurred by claims administrators. For this reason, the proposal fails to comply with the</p>			

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	Government Code Section 11349.1 necessity standard.			
Section 9767.16 (a) and (b)	<p>As provided below, Subdivisions (a) and (b) of Section 9767.16 fails to comply with the Gov. C. Sec. 11349.1 clarity, authority and consistency standards.</p> <p>Section 9767.1 of Chapter 3.5 of Title 8, CCR, defines terms used in the rules governing MPNs. The terms "termination" or "cessation of use" of an MPN are not included in the existing rule's definitions and are not defined here. Since Section 9767.12 already requires 30 days prior notice if the insurer or self-insured employer changes MPNs, it appears that "termination" and "cessation of use" have been used interchangeably.</p> <p>"Termination" is susceptible to various interpretations, including termination of a contract with one MPN and entering into a contract with a different MPN. Section 9767.12 currently requires 30 days prior notice if the insurer or self-insured employer is changing MPNs. Commenter recommends dropping "termination" and defining "cessation of use" as the complete cessation of use of any and all MPNs. Absent such modification, subdivisions (a) and (b) would be unauthorized by and contrary to statute. Both require mailing a notice informing covered employees that they are entitled to select their own physician 30 days from the date of injury. This is not true if the insurer or self-insured employer simply changes networks, although continuity of care requirements would apply if an injured worker</p>	Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment	The Administrative Director accepts this comment. The regulation will be clarified to include both termination of a MPN and cessation of use of a MPN.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>is treating with a terminated provider or provider who is not included in the new network.</p> <p>Commenter recommends that in the event the insurer or self-insured employer ceases to use any MPN, the prior notice period be reduced to 30 days.</p> <p>In subdivision (b), the word "covered has been omitted before the first use of the word "employee." All notices connected with the MPN program are required to be delivered to "covered employees" as that term is defined in Section 9767.1.</p>		<p>The Administrative Director accepts this comment. The prior notice period will be changed to 30-day notice for the employee and 45-day notice to DWC for review and approval of the change.</p> <p>The Administrative Director accepts this portion of the comment. Subsection (b) will be changed to refer to "covered employee."</p>	<p>Amended language has been distributed for public comment.</p> <p>Amended language has been distributed for public comment.</p>
9767.16(c)(1) and (2)	<p>Nothing in statute permits an insured employer to terminate or cease the use of his insurer's MPN, or to contract separately with an MPN to provide medical treatment to his employees. Workers' compensation insurance policies, and the contracts between insured employers and their carriers, specifically grant all authority to insurers to manage all claims against the employers. These subdivisions should be deleted because they fail to comply with the Gov. C. Sec. 11349.1 authority and consistency standards.</p> <p>Regardless of whether employers voluntarily non-renew policies and place coverage with other insurers, or the employers' policies are cancelled by the current insurers, the current insurers remain liable for claims that arose during the policy periods and there would be</p>	Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment	<p>The Administrative Director does not accept these comments. An MPN Applicant, which includes self-insured employers or insurers, may choose to terminate its MPN. An insured employer may choose to switch insurers and change to the MPN of its new insurer, in which case the employer would cease to use the MPN of its former insurer and the provisions of this regulation would apply.</p> <p>Insurers remain liable for the MPN claims that arise under its coverage unless the claim is transferred to a new insurer and its MPN.</p>	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	no interruptions in treatment for those workers already receiving medical care through the insurers' MPNs.			
Section 9810(a)	<p>Because of the considerable demands on programming resources, claims administrators will need sufficient lead time to add new notices, and if the proposed rule is not substantially revised and pared down, to revise all the notices currently in their systems, whether manual or electronic. In 1994, DWC allowed 90 days for the then considerable work entailed in complying with new benefit notice requirements; 120 days would have been more reasonable. The proposed 60 day lead time is not required by statute and is insufficient. The current benefit notice program, to which claims administrators have devoted a great deal of time, effort and expense, has been operating quite satisfactorily for more than a decade.</p> <p>Commenter strongly recommends that DWC allow at least 120 days for claims administrators to make whatever changes are required by adoption of a final rule.</p>	Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment	The Administrative Director accepts this comment and will extend the effective date until 120 days after filing with the Secretary of State.	Amended language has been distributed for public comment.
Section 9810(c)	Amendatory language requires every notice to include the name of the individual claims examiner responsible for payment and adjustment of the claim. Some claims administrators facilitate communication with injured workers who have questions about their claims by assigning dedicated staff to respond to questions and take whatever action is necessary to resolve any problems. Furthermore, if claims examiner staffing assignments change, the name of an individual examiner and that examiner's contact	Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment	The Administrative Director does not accept this comment. An injured worker should be able, when necessary, to contact the individual adjuster responsible for their claim.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	information may be outdated. Staff dedicated to respond can direct inquiries to the appropriate person. Requiring the name of an individual claims examiner effectively dictates an insurer's workflows, even though different approaches to handling inquiries and facilitating action work equally well. As an alternative to providing the name and contact number of an individual adjuster, claims administrators ought to be allowed to include in their notice the phone number of the person or persons to call in case of questions.			
Section 9810(d)	<p>Since notices are required to be available in both English and Spanish, and the Administrative Director is going to make sample notices available on the DWC website, the final sentence should be revised to read:</p> <p><u>The Administrative Director shall make sample notices that comply with these requirements available in English and Spanish on the DWC website.</u></p> <p>Commenter recommends that persons subject to these regulations be given an opportunity to review the content of the sample notices before they are finalized. Last year, he found that many of the sample notices exposed for pre-rulemaking comment contained errors in fact, or errors of omission, and were not readily comprehensible. Delay and denial notices contained one sentence that was 77 words long - clearly falling below a generally accepted level for readability.</p>	Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment	<p>The Administrative Director does not accept this comment. For the most part, these regulations do not mandate the use of specific language in benefit notices – they only mandate specific content</p> <p>The Administrative Director accepts this comment in part, and will convene an advisory group to review the sample notices once they are drafted after finalization of the regulations.</p>	<p>None.</p> <p>An advisory group will be convened to review the sample notices before they are posted.</p>
Section 9810(e)	Although psychiatric reports are the most sensitive and the most likely to be provided upon condition that they not be shared with	Steven Suchil Assistant Vice President American Insurance	The Administrative Director does not accept this comment.	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the physician's patient, physicians other than psychiatrists may also request that only redacted reports or summary reports be shared. The exception to the provision of mandatory reports is unnecessarily narrow. The final rule should also permit insurers to provide copies of medical reports to the extent permitted or not restricted by the physician.	Association December 12, 2006 Written Comment	An injured worker has an absolute due process right to review any and all medical reports concerning their claim, and this right may not be abridged by an evaluating physician or the claims administrator.	
Section 9811(e)	<p>The Labor Code requires inclusion of a statement of employee rights or remedies in the Notice of Potential Eligibility, which accompanies the claim form, with notices denying compensability, with notices that indemnity benefits are ending, and with medical-legal notices. DWC lacks the authority to extend this requirement, and for this reason this regulatory provision fails to comply with the Gov. C. Sec. 11349.1 authority standard. The legislature has chosen not to act in this area and the DWC cannot legislate on its own.</p> <p>Further, there is no practical reason for such an extension. The vast majority of the hundreds of thousands of new claims each year are medical only claims and claims of short duration (three to four weeks) temporary disability. They are paid and closed quickly and without problems of any sort. The inclusion of the lengthy statement of remedies which would be required under this proposal will be counterproductive. The legislature understood this and chose to mandate a statement of remedies only in those situations where the possibility of dispute was more than theoretical.</p>	Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment	The Administrative Director does not accept this comment. The Administrative Director has the authority, pursuant to Labor Code §§ 138.3 and 138.4, and the discretion to prescribe reasonable benefit notice requirements.	None.
Section 9812	Throughout this section, claims administrators	Steven Suchil	The Administrative Director does not	None.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>are required to mail, along with the notices they already provided, "the most recent version" of various DWC "informative pamphlets" or fact sheets. The DWC is not authorized to shift to claims administrators this duty imposed by law.</p> <p>Labor Code Section 139.6 requires the director to establish and maintain a program to provide information and assistance to employees and employers, a program that includes the publication of guides which must be provided to labor and employer organizations and "to any other person upon request." Information and Assistance (I and A) officers are responsible for distributing the pamphlets to injured workers and others who request copies.</p> <p>Furthermore, the legislature twice in the last five years rejected proposals to require claims administrators to provide a comprehensive guide to all injured workers, a guide that was essentially a compilation of the fact sheets, or information pamphlets as they are called here. The DWC cannot by regulation override the express wishes of the legislature.</p> <p>The fact sheets are redundant, duplicative of information provided in the initial Notice of Potential Eligibility, and in the individual benefit notices. Duplication is exacerbated by the proposed requirement to include an employee rights statement (right to contact an I&amp;A officer or attorney, for example) with every notice. Furthermore, as proposed, the claims administrator is required to use "the</p>	<p>Assistant Vice President American Insurance Association December 12, 2006 Written Comment</p>	<p>accept this comment. The Administrative Director has the authority, pursuant to Labor Code §§ 138.3 and 138.4, and the discretion to prescribe reasonable benefit notice requirements. The Division believes that the benefits of the proposed requirement to provide injured workers with informative pamphlets concerning temporary disability benefits, permanent disability benefits or the Agreed Medical Evaluator/Qualified Medical Evaluator ("AME/QME") medical evaluation process outweigh the costs.</p> <p>The Division believes that requiring claims administrators to provide injured workers with a minimal level of basic information concerning the three most important benefits will improve the quality of communication between injured workers and claims administrators, and reduce friction and miscommunications - which may result in a decrease in disputes requiring resolution through litigation.</p>	

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	<p>most recent version." Since revisions can occur at any time, without notice and opportunity to comment, claims administrators could be compelled to provide inaccurate or incomplete information to their policyholders' employees.</p> <p>For the foregoing reasons, this provision fails to comply with the Gov. C. Sec. 11 349.1 authority, clarity and non-duplication standards.</p>			
Section 9812(g)(4)	<p>Labor Code Section 4658, subdivision (d)(3) reads:</p> <p>(3) (A) If, within 60 days of a disability becoming permanent and stationary, an employer offers the injured employee regular work, modified work, or alternative work, in the form and manner prescribed by the administrative director, for a period of at least 12 months, <u>and regardless of whether the injured employee accepts or rejects the offer</u>, each disability payment remaining to be paid to the injured employee from the date the offer was made shall be paid in accordance with paragraph (1) and decreased by 15 percent. (Emphasis added)</p> <p>The statute is unambiguous: a 15% reduction in the PD benefit is not conditioned on the employee's acceptance of the employer's offer. Therefore, the phrase "and acceptance by the injured worker" must be deleted from the final paragraph of the subsection.</p>	<p>Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment</p>	<p>The Administrative Director accepts this comment, and will incorporate the language suggested by State Compensation Insurance Fund in their comment concerning this subdivision.</p>	<p>Amended language has been distributed for public comment.</p>
Section 9812(i)	This Subdivision fails to comply with the	Steven Suchil	The Administrative Director accepts	Amended language has

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	<p>Gov. C. Sec. 11349.1 consistency standard.</p> <p>Labor Code Subdivision 4658, subdivision (c) reads:</p> <p style="padding-left: 40px;">(c) <u>Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with Section 5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for the alleged injury and shall continue to provide the treatment <u>until the date that liability for the claim is accepted or rejected.</u> Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000). (Emphasis added)</u></p> <p>To be absolutely consistent with the statute, and in order not to mislead employees, the second paragraph should be rewritten to read:</p> <p style="padding-left: 40px;">For claims reported on or after April 19, 2004, if the employee has filed a claim form with the employer, the claims administrator shall advise the employee to send for consideration of payment, bills for medical services provided between the date the claim form was given the employer and the date on the denial letter. The claims administrator shall also advise the employee that the maximum payment for medical services that were consistent with treatment guidelines is \$10,000.</p>	<p>Assistant Vice President American Insurance Association December 12, 2006 Written Comment</p>	<p>this comment in part, and will incorporate the suggested language with minor revisions.</p>	<p>been distributed for public comment.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9813.1	<p>This provision fails to comply with the Gov. C. Sec. 11349.1 consistency and non-duplication standards.</p> <p>The final paragraph of this section requires an offer of modified or alternative work to be accompanied by the Request for Dispute Resolution form if the employee rejects the offer or "does not accept or reject" it within 30 days. The language implies that the employee must affirmatively accept the offer, but that is not what Labor Code Section 4658.6 requires as a condition for termination of the employer's liability to provide SJDB voucher. The statutory phrase is, "the employer offers, and the employee rejects, or fails to accept..." There is a distinct difference. The statute clearly means that an employee's failure to respond at all, whether by acceptance or rejection, terminates the employer's liability.</p> <p>Further, extensive, detailed notice requirements governing the Supplemental Job Displacement Benefit are contained in Article 7.5 of Title 8, commencing with Section 10133.50. Their repetition here is entirely unnecessary, duplicative of the existing SJDB rule, and even inconsistent with the statute. For example, subdivisions (3) and (4) use the phrase, "where the injured worker is unable to return to their (sic) usual and customary job..." This wording is a holdover from vocational rehabilitation days, but it is nowhere in the statutory provision creating the benefit, Labor Code 4658.1. That section, defines regular work as "the employee's usual occupation or the position in which the employee was</p>	Steven Suchil Assistant Vice President American Insurance Association December 12, 2006 Written Comment	<p>The Administrative Director accepts this comment in part. The last paragraph will be deleted.</p> <p>This section will be revised to be consistent with the statute and regulations. Because these regulation sections incorporate all benefit notices that are required to be sent to employees, reference to the Notice of Offer or Modified or Alternative Work and the Notice of Regular Work should be included.</p> <p>Subdivision (2), Notice of Regular Work will be deleted as it does not pertain to the supplemental job displacement benefit.</p> <p>Subdivisions (3) and (4) will be</p>	<p>Amended language has been distributed for public comment.</p> <p>Amended language has been distributed for public comment.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>engaged at the time of injury..." There is a distinct difference between an employee's "usual and customary job" and the employee's "usual occupation."</p> <p>Commenter recommends that this entire section be deleted because it is redundant, or that the section simply refer to the existing rule, at the very least, all the language should conform to and be consistent with the statute.</p>		merged as the Notice of Offer of Modified or Alternative Work is one mandatory form. Also, reference will be made to §10133.53 and the language stating "usual and customary job" will be deleted. The last paragraph will be deleted. A new section will be added to list the Return to Work Forms that affect the 15% increase or decrease in permanent disability payments (the Notice of Regular Work and the Notice of offer of Modified or Alternative Work.)	
Section 9767.16(e)	The reference to 30 calendar days as contained within this subsection should be revised to 45 calendar days. The suggested revision would assure that the Division receives notice of termination or cessation of a Medical Provider Network at or about the same time a covered employee receives notice of the termination or cessation of a Medical Provider Network.	Angie Wei Legislative Director California Labor Federation December 11, 2006 Written Comment	The Administrative Director accepts this comment. The regulation will be revised to give DWC 45 days notice to review and approve the change and to give 30 days notice to employees, consistent with the notice required for a change of MPNs under §9767.12.	Amended language has been distributed for public comment.
Section 9810(e)	<p>The language of the existing Section provides that a claims administrator shall make available to the employee, upon request, copies of medical reports other than psychiatric reports which the physician has recommended not be provided to the employee.</p> <p>The Administrative Director proposes to add language to this pre-existing section such that a claims administrator would only be responsible to supply copies of the medical reports upon request by the employee if the claims administrator determines that the</p>	Angie Wei Legislative Director California Labor Federation December 11, 2006 Written Comment	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>requested medical report was relevant to any benefit notice issued. The language proposed by the Administrative Director would also eliminate the obligation of the claims administrator to provide copies of medical reports upon request of the employee if a copy of the medical report had already been provided to the employee. Finally, the Administrative Director would add language to provide that the claims administrator need not provide a copy of the medical report to the employee upon request if the medical report was required to be provided to the employee along with some other unspecified notice.</p> <p>The net effect of the language proposed by the Administrative Director thus reduces a claims administrator's preexisting obligation to provide medical reports to an employee upon the employee's request.</p> <p>Despite the restrictive nature of the language proposed by the Administrative Director in the proposed regulation the Administrative Director states in the Statement of Necessity, "Requiring a claims administrator to make available to an employee, upon request, copies of medical reports, relevant to any benefit notice issued, which have not already been provided, or which are required to be provided along with a notice, is necessary to <u>increase communication</u> and reduce the need to file a claim before the WCAB in order to engage in formal discovery proceedings." (Emphasis added)</p> <p>Commenter suggests that the Statement of</p>			

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	<p>Necessity and the proposed revised language to the preexisting regulation are inherently contradictory.</p> <p>Commenter believes the proposed additional language to this section should be eliminated. Should the Administrative Director refuse to do so the Statement of Necessity should be revised to reflect what is being proposed by the Administrative Director. In particular, the Administrative Director is proposing to provide relief to claim administrators by reducing an employee's right to receive, upon request, copies of medical reports in the file. Placed in such context commenter suggests that there is no means by which the proposed additional language would "increase communication" and that instead the proposed language would reduce communications between injured workers and claims administrators.</p>			
Section 9811(e)	<p>The proposed mandatory statement of employee remedies in a non-ADR setting fails to describe to the unrepresented employee the time frames in which the unrepresented employee must pursue relief and the method which must be utilized by the unrepresented employee to pursue relief. Failure to incorporate such information in adverse benefit notices to unrepresented employees fails to meet the goals of the Statement of Necessity to improve the quality of the information given to injured workers.</p> <p>In a non-ADR setting the Administrative Director proposes that the claims adjuster of the claims administrator fulfill the role of the</p>	Angie Wei Legislative Director California Labor Federation December 11, 2006 Written Comment	<p>The Administrative Director does not accept this comment. The Administrative Director does not believe that this level of detail is appropriate in the benefit notices.</p> <p>The Administrative Director does not accept this comment. The Administrative Director believes that</p>	<p>None.</p> <p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>ombudsperson/mediator in an ADR setting. Commenter believes it is clearly unreasonable to believe a claims adjuster can act as an impartial neutral in a dispute on a claim processed by the claims adjuster. There is nothing within the proposed regulation which would require the claims adjuster to provide specific advice to the unrepresented injured worker of their rights involving the specific benefit dispute.</p>		<p>the claims adjuster is the appropriate first point of contact for an injured worker with questions about their claim. If the injured worker is not satisfied with the claims adjuster's response, or merely wishes to confirm what they were told, the injured worker can contact an I&amp;A officer.</p>	
Section 9812	<p>Through this section, the Administrative Director proposes to excuse claims administrators from providing to unrepresented workers the DWC information pamphlet, "QME/AME Fact Sheet" so long as the unrepresented injured worker received the pamphlet in some earlier notice. Nothing requires the claims administrator when it first transmits the pamphlet to the unrepresented injured worker to advise the unrepresented injured worker to retain the pamphlet for review when subsequent notices are received. Nothing requires the claims administrator in subsequent notices to advise the unrepresented worker to review the pamphlet previously transmitted and which is not included within the subsequent notice due to earlier transmittal of the pamphlet.</p> <p>In its Statement of Necessity the Administrative Director claims, "Requiring the claims administrator to include a copy of the most recent DWC informative pamphlet concerning temporary disability benefits, permanent disability benefits or the Agreed Medical Evaluator/Qualified Medical Evaluator medical evaluation process with</p>	<p>Angie Wei Legislative Director California Labor Federation December 11, 2006 Written Comment</p>	<p>The Administrative Director accepts this comment in part. A notation will be added to each fact sheet advising the recipient to retain the fact sheet for future reference, and to check the DWC website from time to time for updated versions.</p>	<p>The fact sheets have been revised as indicated.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>various benefit notices is necessary to ensure that all injured workers are provided with a minimum level of basic information about potential benefits. This is especially necessary in light of the recent legislative changes to the medical dispute resolution process.” Commenter shares the Administrative Director’s concern to assure that injured workers receive all appropriate information. This is particularly true in terms of unrepresented injured workers who do not have the benefit of counsel. However, the proposed regulations as drafted by the Administrative Director invite claims administrators to bury this information related to the QME process in earlier transmittals and will lead to confusion in terms of unrepresented injured workers. The ability of a claims administrator to not provide a previously transmitted relevant pamphlet in some subsequent notice should be limited solely to represented injured workers. In terms of unrepresented workers the Administrative Director’s proposed exceptions in favor of the claims administrators are contrary to the Statement of Necessity and are arbitrary and capricious.</p>			
Section 9812(i)	<p>Post April 19, 2004 claims, lien claimants as well as injured workers should be instructed to submit bills for medical care to the claims administrator for processing.</p> <p>The Administrative Director proposes that a claims administrator may issue a notice of denial of all liability and would not require the claims administrator to include within the</p>	<p>Angie Wei Legislative Director California Labor Federation December 11, 2006 Written Comment</p>	<p>The Administrative Director does not accept this comment. This instruction is not necessary as providers receive a copy of the notice.</p> <p>The Administrative Director does not accept this comment. Section 10121 concerns tolling of the statute of limitations upon the filing of a claim</p>	<p>None.</p> <p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>notice the actual date on which the claims administrator made the decision to deny all liability.</p> <p>At the time of adoption of amended Labor Code Section 5402(c) the date of rejection of a claim was controlled by Regulation section 10121. That Section stated and continues to state that the date of denial is the date of personal services of the denial for a denial not served by mail. In terms of denial served by mail, section 10121 states that for California residents the date of denial is 5 days after the notice is mailed to the California resident. In terms of a non-California United States resident the date of denial is 10 days after mailing to the non-California U.S. resident. In terms of a non-U.S. resident the date of denial by mail is 20 days subsequent to the mailing of the notice to the non-U.S. resident. The net effect of this regulation proposed by the Administrative Director is to limit a Workers' Compensation insurer's liability for Labor Code section 5402(c) medical care up to as early as 14 days prior to mailing a notice of denial. The net effect of the aforesaid change would be to shift between 19 and 34 days of medical expenses properly payable under Labor Code section 5402(c) by the Workers' Compensation insurer to the Health Plan of the employer in terms of an employee covered by a Health &amp; Welfare plan and to the employee in terms of an employer that does not provide Health &amp; Welfare coverage.</p> <p>The Administrative Director lacks the legal authority to absolve Workers' Compensation</p>		<p>form, not treatment under Labor Code §5402(c). Under proposed §9812 subdivisions (g)(2) and (3), the relevant date is the date that liability is rejected.</p>	

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	<p>insurers of their liability under Labor Code section 5402(c).</p> <p>Even if the Administrative Director had a right to shift liability away from Workers' Compensation insurers the Initial Statement of Reasons fails to discuss the significant adverse impact the proposal would have upon businesses that provide employees with Health &amp; Welfare coverage. In particular, the proposal by the Administrative Director would create a liability that, but for the regulation, would be borne by the employer's Workers' Compensation insurer.</p>			
Section 9812(j)	In Section 9812(j) the Administrative Director has properly provided that a claims administrator provide a copy of the "Notice Denying Liability for All Compensation Benefits" to lien claimants or persons or entities who can reasonably be identified by the claims administrator from information in the claims file to be potential lien claimants on account of their having furnished benefits, goods or services for which a lien may be filed. The same persons or entities should receive a copy of the Notice of Delay in Determining all Liability for claims reported on or after April 19, 2004.	Angie Wei Legislative Director California Labor Federation December 11, 2006 Written Comment	The Administrative Director does not accept this comment. A copy of the notice at this time would be premature. The provider will receive a copy of the appropriate notice at the time the claim is accepted or denied.	None.
General comment	<p>Commenter alleges that a careful review of the proposed regulations leads to the inescapable conclusion that unrepresented injured workers will not receive adequate information as to medical reports.</p> <p>Labor Code section 5402(c) is unique in that for claims incurred on and after April 19, 2004 a Workers' Compensation insurer is</p>	Angie Wei Legislative Director California Labor Federation December 11, 2006 Written Comment	<p>This comment repeats the more specific comment made above with respect to §9812(i). The response to that comment is hereby incorporated by reference.</p> <p>This comment repeats the more specific comment made above with respect to §9811(e). The response to</p>	<p>None.</p> <p>None.</p>

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>liable for medical treatment up to \$10,000.00 until liability for a claim is rejected. This benefit for workers in need of medical care is effectively eliminated by the Administrative Director's proposal to permit claims administrators to provide tardy notices of rejection of claims. The concept of permitting tardy notice of rejection of claims also creates liability for health plans that provide medical coverage in reliance upon the provisions if Labor Code section 5402(c).</p> <p>The proposed regulations as drafted also endanger the rights of unrepresented workers by not providing them with adequate notice of their rights and the need to timely seek appropriate remedies through appropriate procedures.</p>		that comment is hereby incorporated by reference.	
Section 9767.16	<p>Regarding the MPNs, commenter requests that the Division include a paragraph or two toward the end that would take care of the situation whereby perhaps an IMR is already involved in the case at which time the employer dissolved the MPN.</p> <p>Commenter believes there should probably be a paragraph, for instance, the worker may be working her way up from the treating physician to the second opinion to the third opinion. If the worker is treating with a treating physician and then goes up to the second level opinion and the third level opinion, commenter thinks the Division needs something to stop that process if the MPN is dissolved. It could be just a paragraph to make it clear that the worker then is going free choice. And it's more important if the process</p>	David W. O'Brien, Esq. Retired WCALJ Floyd, Skeren & Kelly December 12, 2006 Oral Comment	The Administrative Director accepts this comment in part. The proposed regulation has been amended to require that covered employees be informed that "Upon termination or cessation of use, any pending Independent Medical Review under that MPN shall also be terminated."	Amended language has been distributed for public comment.

BENEFIT NOTICES	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	has gone to the IMR doc because she may have an exam scheduled. Those two things should be covered.			
General Comment Concerning Benefit Notices	<p>Commenter has gotten a lot of phone calls from a lot of his friends about another layer of forms. Commenter believes that the temporary disability information and the permanent disability information and the supplemental job displacement benefit information is adequately covered under Labor Code section 3550 where all injured workers -- all workers on the day of hire or within the first pay period get a booklet. That booklet is set forth in the Division's Regulations, section 9880. Commenter believes that it's redundant to again give an injured worker the temporary disability information all over again and the P.D. information all over again.</p> <p>Commenter states that we are the most form intensive state in the nation. There are 97 forms we now mandate. We're going to add a couple more. Commenter refers to Labor Code section 3550 and Regulation 9880 and states that if all employers comply, hopefully, then you won't need to give another pamphlet out when someone is injured explaining T.D. because they already know about that. Commenter states that he loves our notices and regulations are well done, but he doesn't think it necessary to saddle employers with another requirement to attach another pamphlet to those notices.</p>	David W. O'Brien, Esq. Retired WCALJ Floyd, Skeren & Kelly December 12, 2006 Oral Comment	The Administrative Director does not accept this comment. Workers' compensation is a complex area of the law, and injured workers require timely and up-to-date information. The Administrative Director does not believe that the initial hire booklet -- if the employee retained it -- is an adequate substitute for information relevant to a benefit at the time it is provided or denied.	None.
Section 9812	Commenter agrees with Mark Hayes regarding the issue of giving notice to the unrepresented people because he believes	Stanley Levine Co-Chair Regulations Committee -- California	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.

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	these people aren't going to be able to see what is there and that they get mail and they don't open it up that day. Commenter also believes that having something on the outside of the envelope that reads "Important, Read Now" would be beneficial.	Applicants' Attorneys Association December 12, 2006 Oral Comment		
Genera Comment Concerning Benefit Notices	<p>Commenter disagrees with the idea that there are too many notices. Commenter believes that there is a need to keep reinforcing information because the great majority of people in this state are still unrepresented.</p> <p>Commenter believes that many injured workers can't read very well. Commenter believes the Division is correct in requiring notices. Commenter realizes the insurance industry and self-insurers may feel burdened by the extra paperwork, but he believes the effort is worthwhile if you save a few people from making a major mistake regarding their case.</p>	Stanley Levine Co-Chair Regulations Committee – California Applicants' Attorneys Association December 12, 2006 Oral Comment	While the Administrative Director appreciates this comment, the comment does not constitute an objection or recommendation that requires explanation or accommodation pursuant to Government Code §11346.9(a)(3).	None.
Section 9811	<p>Commenter points out the new language on Alternative Dispute Resolution includes attorneys in the process where-as the old language does not.</p> <p>Commenter would like the Division to consider keeping the old language over the new language.</p>	Stanley Levine Co-Chair Regulations Committee – California Applicants' Attorneys Association December 12, 2006 Oral Comment	The Administrative Director does not accept this comment. The right to legal representation under an ADR program depends on whether the ADR program is established under Labor Code §§ 3201.5 or 3201.7.	None.
Section 9812(f)(2)	In proposed section 9812(f)(2) which deals with revisions of the P.D. benefit notice for injuries in 1991, 1992 and 1993, there is a provision that's added as part of the mandatory QME language. A requirement to advise a represented employee if no agreement on an AME can be reached, the injured worker may be evaluated by a QME pursuant to Labor	Patrick Humphrey December 12, 2006 Oral Comment	The Administrative Director accepted these comments and responded to them in earlier comments on these subdivisions.	Amended language has been distributed for public comment.

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	Code section 4062.2 but – commenter is not a lawyer but it's his understanding that 4062.2 only pertains to injuries for date of injury 1-1-05 and after. And if that's correct why is that part of a section of the notice that clearly seems to pertain to injuries dated 1991, 1992 and 1993? It does pertain -- it would be appropriate for the section for injuries 1-1-94 and after, but it seemed out of place for the section concerning that window period.			
Section 9813.1	<p>The Notice of Supplemental Job Displacement, Number 2, the Notice of Regular Work. Commenter is pleased that the Division has chosen to allow this form, Form 10003, to be used for the purpose of an offer of regular work. And if that's made of course in the form and manner prescribed by the Admin. Director then, as the commenter understands it, supplemental job displacement benefit obligation has been fulfilled.</p> <p>Commenter wants to point out that the current notice clearly states at the top for injuries 1-1-05 and after, but if it's going to be used for injuries occurring on or after January 1, '04, the Division should modify that or get rid of that altogether.</p>	Patrick Humphrey December 12, 2006 Oral Comment	<p>The Administrative Director accepts this comment.</p> <p>The commenter correctly points out an error. Form 10003 is for injuries that occur 1/1/05 and after. Also, in order for the employer not to be liable for the SJDB, Labor Code §4658.6 only authorizes offers of modified or alternative work, not regular work.</p> <p>Subdivision (2), Notice of Regular Work will be deleted as it does not pertain to the supplemental job displacement benefit.</p> <p>A new section will be added for injuries that occur on or after 1/1/05 for the Return to Work Forms that affect the 15% increase or decrease in permanent disability payments (the Notice of Regular Work and the Notice of offer of Modified or Alternative Work.)</p>	Amended language has been distributed for public comment.
General Comment Concerning Benefit	Commenter has a comment about the forms. It is of course a burden. Commenter	Patrick Humphrey December 12, 2006	While the Administrative Director appreciates this comment, the	None.

<b>BENEFIT NOTICES</b>	<b>RULEMAKING COMMENTS 45 DAY COMMENT PERIOD</b>	<b>NAME OF PERSON/ AFFILIATION</b>	<b>RESPONSE</b>	<b>ACTION</b>
Notices	<p>understands and has anticipated that there would be a need to translate in Spanish all of the forms and notices. There are a lot of forms but commenter has no issue with that.</p> <p>Commenter would like to know if the division is contemplating a change to the current QME Request Panel Form which still refers to the Industrial Medical Council. Commenter doesn't even know that the address is correct. In the past he's sent it to an address and had it returned marked addressee unknown or cannot forward. Commenter requests that the division work on correcting these forms as a part of these notices.</p>	Oral Comment	<p>comment does not constitute an objection or recommendation that requires explanation or accommodation pursuant to Government Code §11346.9(a)(3).</p> <p>This comment is unrelated to benefit notice regulations and is therefore beyond the scope of the regulatory proceeding.</p>	None.
Section 9767.16	The regulations should state that after termination of a MPN, any ongoing Independent Medical Review process will be terminated.	David O'Brien	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.
Section 9767.16	Rule isn't clear on notices given to workers with open claims and those that don't; the regulations don't specifically address TPA changes to the MPN; questions the 45-day employee notice requirement and the 30-day notice requirement to DWC; MPN applicant should be responsible for DWC filing, not the MPN; notice requirements don't match real world practice and will be hard to implement	<p>Steve Cattolica</p> <p>E-mail dated March 9, 2007 (Although untimely for the public comment period, the Administrative Director deems the comments sufficiently important to accept them and respond to them as part of this rulemaking)</p>	The Administrative Director accepts this comment.	Amended language has been distributed for public comment.